2025 External Quality Review Compliance Review

for

Humana Healthy Horizons

December 2025

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1. Executive Summary

Introduction

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Louisiana Department of Health (LDH) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid ambulatory health plan's (PAHP's), or prepaid inpatient health plan's (PIHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As LDH's EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review (CR) activity with each of the Healthy Louisiana MCOs, PAHPs, and the PIHP delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the CR, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Apr 1, 2025.

Summary of Compliance Review Results

Table 1-1 presents an overview of the results of the 2025 CR for Humana Healthy Horizons (HUM). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards. Refer to appendices B and C for a detailed description of the findings.

Table 1-1—Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	3	6	3	33%
II	Member Rights and Confidentiality	24	24	24	0	0	100%
III	Member Information	19	18	13	5	1	72%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	14	6	8	1	43%
VI	Coordination and Continuity of Care	12	12	10	2	0	83%
VII	Coverage and Authorization of Services	23	21	20	1	2	95%
VIII	Provider Selection	19	19	13	6	0	68%
IX	Subcontractual Relationships and Delegation	6	6	4	2	0	67%
X	Practice Guidelines	6	6	6	0	0	100%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	31	6	1	84%
XIV	Program Integrity	18	18	18	0	0	100%
Total Compliance Score		**227**	**217**	**181**	**36**	**10**	**83%**

M=*Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The **total** number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the managed care entities (MCEs) for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 2-1 outlines the division of standards reviewed in calendar year (CY) 2021, CY 2022, CY 2023, and CY 2024.

Table 2-1—CR Standards

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III—Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓				-	✓	✓	✓
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§438.608	✓	✓	✓				-	✓	✓	✓

[1] The CR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the CR, HSAG developed data collection tools, referred to as "CR tools," to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs' compliance were consistent with CMS EQR Protocol 3.

For each of the MCEs, HSAG's desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an information systems (IS) review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified, and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, case management, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service

authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for case management with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE's key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025-September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

3. Corrective Action Plan Process

HUM is required to submit to the HSAG SAFE site a CAP for all elements scored as *Not Met*. Appendix C contains the CAP template that HSAG prepared for HUM to use in preparing its plans of action to remediate any deficiencies identified during the 2025 CR. The CAP template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and required actions documented to bring HUM into full compliance with the deficient requirements. HUM must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). HUM's CAP template and evidence of implementation must be submitted to the HSAG SAFE site **no later than 60 calendar days from receipt of the final report**.

The following criteria will be used by HSAG and LDH to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that HUM will implement to bring the element into compliance.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The degree to which the planned interventions brought HUM into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the MCO until approved by HSAG and LDH. LDH maintains ultimate authority for approving or disapproving any corrective action strategies proposed by HUM in its submitted CAP.

Appendix A. Conclusions and Recommendations

Strengths	
+	The MCE received 100 percent compliance with Standard II—Member Rights and Confidentiality, indicating that members were receiving timely and adequate access to information that could assist them in access care and services.
+	The MCE received 100 percent compliance with Standard IV—Emergency and Poststabilization Services, demonstrating that the MCE had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services.
+	The MCE effectively adopted practice guidelines in consensus with network providers and had a system in place for dissemination to providers and members. In addition, the MCE received 100 percent compliance with Standard X—Practice Guidelines.
+	The MCE received 100 percent compliance with Standard XI—Health Information Systems, demonstrating that the MCE had a robust health information system for processing and managing member data, provider data, and claims processing, while ensuring data security and facilitating data reporting.
+	The MCE received 100 percent compliance with Standard XII—Quality Assessment and Performance Improvement and demonstrated detailed documentation, indicated methods to monitor quality of care, analyzed over- and underutilization, and ensured improved outcomes for members with special health care needs.
+	The MCE received 100 percent compliance with Standard XIV—Program Integrity, demonstrating that the MCE had appropriate processes to monitor, identify, plan, and mitigate fraud, waste, and abuse. Furthermore, the MCE developed a compliance committee to ensure information sharing at the staff, management, and leadership levels.

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations	
−	The MCE should review the CR tool and its detailed findings and recommendations. Specific required actions and recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.

Appendix B. 2025 Compliance Review Tool

This appendix includes the completed review tool that HSAG used to evaluate HUM’s performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring HUM’s performance into full compliance.

Standard I—Enrollment and Disenrollment Requirements and Limitations

<table>
<tr><th colspan="3">Standard I—Enrollment and Disenrollment Requirements and Limitations</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><th colspan="3">Disenrollment Requested by the MCE</th></tr>
<tr><td rowspan="2">1. The MCE may request disenrollment of a member in the following circumstances:
a. When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department
b. Upon termination or expiration of the Contract
c. Death of the member
d. Confinement of the member in a facility or institution when confinement is not a covered service under the Contract
PAHP:
a. The Contractor may request involuntary disenrollment of an enrollee if the enrollee's utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee's ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).
PIHP:
a. The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.
42 CFR §438.56(b)(1)
42 CFR §457.1212
MCO Contract: 2.3.12.3.2
PAHP Contract: 2.3.7.3.5; 2.3.7.3.1
PIHP Contract: 10.1.6</td><td>HSAG Required Evidence:
• Policies and procedures
• State-specific workflow for MCE-initiated disenrollment requests
• Member materials, such as the member handbook
• One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request (if the MCE has not requested disenrollment of a member please state so under the MCE Description of Process)</td><td rowspan="2">☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S1.1_Disenrollment; page 1
• S1.1_Workflow Narrative; entire document
• S1.1_Member Handbook; pages 56 & 57
• S1.1_Example Narrative; entire document</td></tr>
</table>

<table>
<tr><th colspan="3">Standard I—Enrollment and Disenrollment Requirements and Limitations</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCE Description of Process: The process for member disenrollment and termination at Humana Healthy Horizons in Louisiana (Humana) is governed by the contract with the Louisiana Department of Health (LDH). Members may request disenrollment for cause or without cause, under specific circumstances outlined in the policy, while the contractor may request involuntary disenrollment only for reasons such as fraud or abuse, and not due to adverse health status or uncooperative behavior resulting from special needs. All disenrollment requests are submitted to the state's enrollment broker for review and approval, with decisions at the sole discretion of LDH or its designee. The effective date for disenrollment is no later than the first day of the second month following the request, and until disenrollment is finalized, the contractor remains responsible for providing covered services. During the scope of this audit, Humana did not request disenrollment for a member. Our standard process was to react to enrollment information from the 834 as received from LDH and not disenroll a member unless requested to do so by LDH.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The policies did not describe that HUM may request disenrollment for the reasons stated in the requirement.</td></tr>
<tr><td colspan="3">Required Actions: The MCE must revise or develop a policy to comply with the requirements for this element.</td></tr>
<tr><td rowspan="2">2. The MCE does not request disenrollment because of:
MCO & PAHP:
a. An adverse change in the member’s health status; or
b. Because of the member’s health diagnosis
c. The member’s utilization of medical services
d. The member’s diminished mental capacity
e. The member’s pre-existing medical condition
f. The member’s refusal of medical care or diagnostic testing
g. The member’s attempt to exercise his/her rights under the Contractor’s Grievance system
h. The member’s attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned
i. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued</td><td>HSAG Required Evidence:
• Policies and procedures
• Report of MCE-initiated requests for disenrollment of members during the past 12 months, including the reason for requesting the disenrollment (if the MCE has not requested disenrollment of a member please state so under the MCE Description of Process)</td><td rowspan="2">☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S1.2_MCC Disenrollment; page 1
• S1.2_Disenrollment; page 1</td></tr>
</table>

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
enrollment in the MCE seriously impairs the MCE's ability to furnish services to either this particular member or other members). PIHP: a. The member's adverse change in health status b. The member's utilization of medical services c. The member's diminished mental capacity d. The member's uncooperative or disruptive behavior resulting from his or her special needs 42 CFR §438.56(b)(2) 42 CFR §457.1212 MCO Contract: 2.3.13.3.4 PAHP Contract: 2.3.7.3.4 PIHP Contract: 10.1.5		
MCE Description of Process: Humana did not request disenrollment for a member during the past twelve months and therefore, does not have a MCE-Initiated request report to submit. Our standard process was to react to enrollment information from 834 as received from LDH and not disenroll a member unless requested to do so by LDH.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The policies did not describe that HUM does not request disenrollment for the reasons stated in the requirement.		
Required Actions: The MCE must revise or develop a policy to comply with the requirements for this element.		
3. The MCE assures the State that it does not request disenrollment for reasons other than those permitted under the contract. MCO & PAHP: a. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO/PAHP is not requesting disenrollment for other reasons by reviewing and	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request	☐ Met ☒ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard I—Enrollment and Disenrollment Requirements and Limitations</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker.
PIHP:
a. The PIHP shall not request disenrollment for reasons other than those stated in the Contract. The PIHP may not disenroll Coordinated System of Care (CSoC) members for any reason other than discharge from CSoC. Eligible members may choose to no longer participate in CSoC, in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge.
42 CFR §438.56(b)(3)
42 CFR §457.1212
MCO Contract: 2.3.13.3.5
PAHP Contract: 2.3.7.3.5
PIHP Contract: 10.1.6</td><td>Evidence as Submitted by the MCE:
• S1.3_Disenrollment; page 1
• S1.3_Contract Training; entire document
• S1.3_Example Narrative; entire document</td><td></td></tr>
<tr><td colspan="3">MCE Description of Process: During the scope of this audit, Humana’s standard process was to react to enrollment information from the 834 as received from LDH and not disenroll a member unless requested to do so by LDH. In calendar year 2024, Humana did not request disenrollment for a member.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The policies did not reflect assurance to the State that HUM does not request disenrollment for reasons other than those permitted under the contract.</td></tr>
<tr><td colspan="3">Required Actions: The MCE must revise or develop a policy to comply with the requirements for this element.</td></tr>
</table>

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the Member		
4. The member may request disenrollment from the MCE as follows: a. Without cause, at the following times: MCO: i. During the disenrollment period offered to Enrollees at the start of the contract. ii. During the 90 days following the date of the member's initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later. iii. At least once every 12 months thereafter (during the enrollment period). iv. At least once every 12 months thereafter. v. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. vi. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S1.4_MCC Disenrollment; page 2 • S1.4_Member Handbook; page 56	☐ Met ☒ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
vii. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. PAHP: i. During the 90 days following the date of the member's initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later. ii. At least once every 12 months thereafter. iii. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. iv. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act. v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. 42 CFR §438.56(c) 42 CFR§438.56(g) 42 CFR §438.702(a)(4) 42 CFR §457.1212 MCO Contract: 2.3.13.2.2 PAHP Contract: 2.3.7.2.2 PIHP Contract: NA		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The process for member disenrollment from Humana Healthy Horizons in Louisiana involves Call Center Customer Care Advocates (CCAs) assisting members with their requests. Members may disenroll without cause within the first 90 days of enrollment or during annual re-enrollment periods; after this period, disenrollment requires a cause as determined by the Louisiana Department of Health (LDH). CCAs attempt to resolve any member concerns before proceeding, and if the member still wishes to disenroll, the request is referred to LDH for approval.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's policies did not reflect the reasons members may request disenrollment without cause.		
Required Actions: The MCE must revise or develop a policy to comply with the requirements for this element.		
Procedures for Disenrollment		
5. The following are causes for disenrollment: MCO: a. The member moves out of the MCE's service area; b. The MCE does not (due to moral or religious objections) cover the service the member seeks; c. The member needs related services to be performed at the same time; not all related services are available from the MCE's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; d. Poor quality of care; e. Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; f. The Contract between the MCE and LDH is terminated; g. The member's active specialized behavioral health provider ceases to contract with the MCE for reasons	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S1.5_MCC Disenrollment; page 2 • S1.5_Member Handbook; pages 56-57	☐ Met ☒ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
other than noncompliance with the Network Provider Agreement of this Contract; or h. Any other reason deemed to be valid by LDH and/or its agent. PAHP: a. The MCE does not (due to moral or religious objections) cover the service the member seeks; b. The member needs related services to be performed at the same time, not all related services are available from the MCE's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; c. Poor quality of care; d. Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; e. The Contract between the MCE and LDH is terminated; f. Any other reason deemed to be valid by LDH and/or its agent. 42 CFR §438.56(d)(2) 42 CFR §457.1212 MCO Contract: 2.3.13.2.1 PAHP Contract: 2.3.7.2.1 PIHP Contract: NA		
MCE Description of Process: According to the Humana Healthy Horizons in Louisiana policy, members may request disenrollment from the plan for specific cause reasons determined by the Louisiana Department of Health (LDH). Valid causes include situations such as the member moving out of the service area, their primary care provider no longer being in-network, lack of access to covered services, or the plan not		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
covering a service for moral or religious reasons. If a member seeks disenrollment for cause, Customer Care Advocates (CCAs) are required to follow the Grievance for Medicaid procedures and refer the request to LDH for review and approval.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's policies did not reflect the reasons members may request disenrollment with cause.		
Required Actions: The MCE must revise or develop a policy to comply with the requirements for this element.		
6. The member must request disenrollment by submitting an oral or written request (as required by the State): a. To the State or its agent; or b. To the MCE, if the State permits MCEs to process disenrollment requests. 42 CFR §438.56(d)(1) 42 CFR §457.1212 MCO Contract: 3.1.12.4.1.2 PAHP Contract: None PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow delineating State and MCE responsibilities • Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter) **Evidence as Submitted by the MCE:** • S1.6_MCC Disenrollment; page 1 • S1.6_Member Handbook; pages 49-50 • S1.6_MCC Disenrollment; entire document • S1.6_Example Narrative; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Members wishing to disenroll from Humana Healthy Horizons in Louisiana may submit a disenrollment request either orally or in writing. Such requests should be directed to the Louisiana Department of Health (LDH) or its designated Enrollment Broker, as Humana does not process disenrollment directly. The State does not permit Humana to receive disenrollment requests from the member. Humana receives their guidance from the State. If a member contacts Humana with a disenrollment request, the Customer Care Advocate (CCA) will attempt to address any concerns and, if the member still wishes to proceed, will refer the request to LDH for review and decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

<table>
<tr><th colspan="3">Standard I—Enrollment and Disenrollment Requirements and Limitations</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">7. When the MCE’s contract with the State permits the MCE to process disenrollment requests, the MCE may either approve a request for disenrollment by or on behalf of a member or the MCE must refer the request to the State.
42 CFR §438.56(d)(3)(i)
42 CFR §457.1212
MCO Contract: NA
PAHP Contract: NA
PIHP Contract: NA</td><td>HSAG Required Evidence:
• Policies and procedures
• Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter, review conducted by the MCO, decision made by the MCO, reporting to the State)</td><td rowspan="2">☐ Met
☐ Not Met
☒ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S1.7_Enrollment File Processing; page 1</td></tr>
<tr><td colspan="3">MCE Description of Process: Prior to 2025, all disenrollment requests were handled by LDH and processed as received on the 834 files. The MCE contracts did not allow MCEs to approve disenrollments during this audit period.</td></tr>
<tr><td colspan="3">HSAG Findings: The State retains authority over all disenrollment decisions, so the MCE is not able to process a disenrollment request; therefore, HSAG has determined that this requirement is not applicable.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td colspan="3">Use of the MCE’s Grievance Process</td></tr>
<tr><td>8. (If the State contract requires) The member must seek redress through the MCE’s grievance process before making a determination on the member’s request:
a. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR §438.56(e)(1)—regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following</td><td>HSAG Required Evidence:
• Policies and procedures
• Member materials, such as the member handbook
• Three case examples of a member request for disenrollment grievance record, including the resolution letter
• Referrals to the State for member termination from MCE</td><td>☐ Met
☐ Not Met
☒ NA</td></tr>
</table>

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
the month in which the enrollee requests disenrollment or the MCE entity refers the request to the State. b. If, as a result of the grievance process, the MCE approves the disenrollment, the State agency is not required to make a determination to approve or disapprove the disenrollment request. 42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) 42 CFR §457.1212 MCO Contract: 2.15 PAHP Contract: NA PIHP Contract: NA	• Report of member disenrollment requests during the past 12 months, including the reason for the disenrollment (e.g., grievance report) **Evidence as Submitted by the MCE:** • N/A	
MCE Description of Process: This is not a State contract requirement.		
HSAG Findings: The state contract does not require a grievance process as described in this element; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
9. If the MCE or State agency or its designee fails to make a disenrollment determination so that the member can be disenrolled within the timeframes specified in 42 CFR §438.56(e)(1), the disenrollment is considered approved. 42 CFR §438.56(d)(3)(ii) 42 CFR §457.1212 MCO Contract: 2.3.13.4.2 PAHP Contract: 2.3.7.4.2 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • S1.9_Disenrollment; page 1	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: During this audit period, LDH made all disenrollment decisions.		
HSAG Findings: The MCE is not responsible for making disenrollment determinations; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Enrollment		
10. The MCE agrees to accept individuals enrolled into its MCE in the order in which they apply without restriction (unless authorized by the Department). The MCE may not prescreen select potential members on the basis of pre-existing health problems. MCO and PAHP: a. *The Contractor shall accept new Enrollment of Beneficiaries in the order in which they are submitted by the Enrollment Broker without restriction as specified by LDH, up to the limits set under the Contract with LDH [42 CFR §438.3(d)(1)]. Enrollment is voluntary, except in the case of Mandatory MCO Populations that meet the conditions set forth in 42 CFR §438.50(a).* PIHP: a. *The Contractor shall accept referrals of individuals for CSoC consideration in the order in which they are referred, without restriction. The Contractor shall complete the brief CANS in order to determine if the child/youth is presumptively clinically eligible for CSoC. If the child/youth meets presumptive clinical eligibility, the Contractor will build a thirty (30) day authorization and make referral within twenty-four (24) hours to the WAA. The Contractor shall make a referral to the FSO within twenty-four (24) hours of notification of member's choice. The WAA shall ensure that the*	**HSAG Required Evidence:** • **Evidence as Submitted by the MCE:** • S1.10_Enrollment File Processing; pages 1 & 2 • S1.10_New Enrollees; page 1 • S1.10_Eligibility Groups; page 3	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
independent assessment is conducted to determine clinical eligibility. 42 CFR §438.3(d)(1) MCO Contract: 2.3.12.1.2 PAHP Contract: 2.3.4.1.2 PIHP Contract: 10.1.2		
MCE Description of Process: Humana Healthy Horizons in Louisiana follows a structured process to ensure that Medicaid-eligible enrollees are accurately enrolled and provided with the appropriate managed care benefits as outlined in the state contract. This process does not included prescreening potential members on the basis of pre-existing health problems. Enrollment files are retrieved daily from the state portal, verified for accuracy and completeness, and mapped to the correct benefits before being processed.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The MCE does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability. 42 CFR §438.3(d)(3-4) MCO Contract: 2.3.12.1.3 PAHP Contract: 2.3.4.1.3 PIHP Contract: 10.1.3; 10.1.4	**HSAG Required Evidence:** • Enrollment policies and procedures • Member handbook **Evidence as Submitted by the MCE:** • S1.11_Contractor Enrollment; page 1 • S1.11_Member Handbook; page 24	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Contractor Enrollment Procedures for Humana Healthy Horizons in Louisiana outline the steps and requirements for enrolling contractors in compliance with state and federal regulations. The process mandates strict adherence to non-discrimination policies as per ACA 1557. In virtual review, staff described system functions that automatically process the 834 file without manual manipulation to prevent discrimination or screening.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
12. If the Department approves the MCE's disenrollment request, the MCE gives the member 30 days written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State Fair Hearing. MCO: a. The notice shall include: i. The reason for the disenrollment; ii. The effective date of the disenrollment; iii. An instruction that the Enrollee choose a new MCO; and iv. A statement that if the Enrollee disagrees with the Disenrollment decision, the Enrollee has a right to submit a request for a State Fair Hearing. PAHP: a. The notice shall include: i. The reason for the disenrollment; ii. The effective date; iii. An instruction that the enrollee choose a new DBPM; and iv. A statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a State Fair Hearing. 42 CFR §438.56(d)(5) MCO Contract: 2.3.13.3.7 PAHP Contract: 2.3.7.3.7 PIHP Contract: NA	**HSAG Required Evidence:** • Enrollment policies and procedures • Member notification letter template **Evidence as Submitted by the MCE:** • S1.12_Enrollment File Processing; entire document • S1.12_Member Disenrollment Request; entire document • S1.12_Disenrollment; page 1 • S1.12_Letter Narrative; entire document	☐ Met ☒ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: During the scope of this audit, Humana did not request disenrollment for a member.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The policies did not describe HUM's compliance with providing member notice nor was a member notification template submitted.		
Required Actions: The MCE must revise or develop a policy and member notification template to comply with the requirements for this element.		

Results for Standard I—Enrollment and Disenrollment Requirements and Limitations							
Total	Met	=	3	X	1	=	3
	Not Met	=	6	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	9	**Total Score**		=	3

Total Score ÷ Total Applicable	=	**33%**

Standard II—Member Rights and Confidentiality

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCE has written policies regarding member rights. 42 CFR §438.100(a)(1) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 2.9.1.9 PIHP Contract: 5.13.2.2	**HSAG Required Evidence:** • Member rights policy **Evidence as Submitted by the MCE:** • S2.1_Enrollee Rights and Responsibilities; page 1	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The process for establishing Enrollee rights and responsibilities, ensures that all Enrollee rights are communicated through both oral and written notifications and are consistently protected by Humana Healthy Horizons in Louisiana (Humana) associates and subcontractors. Humana guarantees each Enrollee the right to dignity, privacy, informed decision-making regarding healthcare, freedom from inappropriate restraint or seclusion, and access to their health records as specified by federal regulations. Additionally, Humana commits to non-retaliation for Enrollees exercising their rights and provides comprehensive information in the Enrollee Handbook. Compliance with all relevant federal and state laws is mandatory, and noncompliance may result in disciplinary actions, including termination of employment or services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE complies with any applicable Federal and State laws that pertain to member rights and ensures that it's employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.1.9; 2.6.9.13, 6.7.1 PIHP Contract: 5.13.2.4	**HSAG Required Evidence:** • Policies and Procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms • Grievance log over the time period of review with member rights grievances	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S2.2.1_LA Privacy Policy Summary, pages 2-3 • S2.2.1_Enrollee Rights and Responsibilities; page 1-2 • S2_2.2_LA Narrative_Provider Manual, entire document • S2_2.2_2023 Provider_Manual, pages 68-69 • S2_2.2_LA_Phy_Agreement, page 11 • S2_2.2_LA Orientation 2024, entire document • S2_2.2_LA Member Rights, pages 10-11 • S2_2.2_LA Contract Training, pages 36-37 • S2_2.3_2024 Ethics & Compliance Training, entire document • S2_2.3_LA Member Rights, pages 10-11 • S2_2.3_LA Contract Training, pages 36-37 • S2_2.4_LA Privacy-Risk Assessment, pages 1-2 • S2_2.5_LA Grievance Log, entire document	
MCE Description of Process: Humana maintains compliance with all applicable Federal and State laws related to member rights, including 42 CFR §438.100(a)(2), 42 CFR §457.1220, and MCO Contract section 2.13.1.1, by developing, implementing, and annually reviewing comprehensive privacy and member rights policies. These policies apply to all associates, contractors, and vendors.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Specific Rights		
3. The MCE complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b-d) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 6.4 PIHP Contract: 5.13.1.1	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook • HSAG will also use the results of the Member Rights Checklist **Evidence as Submitted by the MCE:** • S2_3.1_Enrollee Rights and Responsibilities, entire document • S2_3.2_Member_Handbook, pages 6-8 **Additional Documentation:** • Medicaid IT Provisions • LA Medicaid Provider Relations • Provider Manual (and associated redline versions and LDH approval emails) • Provider Orientation and Training	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures compliance with federal and state requirements regarding member rights by clearly outlining and upholding those rights in its Member Handbook and operational policies. Members are informed of their rights to receive information about the Humana and its services, be treated with dignity and respect, participate in decision-making regarding their healthcare, and access their medical records in accordance with 42 CFR §438.100(b-d) and §457.1220. The organization prohibits discrimination and guarantees the right to file grievances and appeals without retaliation. These practices are regularly reviewed to maintain alignment with applicable regulations and contractual obligations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the MCE add specific information about member rights to the provider orientation training materials.		
Required Actions: No action required.		
General Rule		
4. For medical records and any other health and enrollment information that identifies a particular member, the MCE uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. a. The MCO designates a privacy official who is responsible for the development and implementation of the policies and procedures of the MCO. b. The MCO designates a contact person or office who is responsible for receiving privacy-related complaints and who is able to provide further information about matters covered by the notice required by 45 CFR §164.520. c. The MCO trains all members of its workforce on the policies and procedures with respect to protected health information (PHI) as necessary and appropriate for the members of the workforce to carry out their functions within the MCO as outlined in 45 CFR §164.530. d. The MCO has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. 42 CFR §438.224 42 CFR §457.1110 45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E	**HSAG Required Evidence:** • Policies and procedures (should address all components of 45 CFR part 164 subpart E) • Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder records • Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information • Employee-facing materials • Staff training materials **Evidence as Submitted by the MCE:** • S2.4.1_LA Privacy Policy Summary, pages 2-3 • S2.4.2_Workflow, entire document • S2_4.3_LA_Phy_Agreement, pages 7,22,23,24,27-28 • S2_4.3_Provider Manual, pages 8,80-81 • S2_4.4_LA Privacy Policy Summary, page 2	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 6.22 PAHP Contract: 2.1.4.1 PIHP Contract: 20.12	• S2_4.4_Privacy Summary, pages 5-6 & Pages 11-17 • S2_4.5_2024 Ethics & Compliance Training, pages 99-109 **Additional Documentation:** • Medicaid IT Provisions • Policy – EIP – Enterprise Information Protection (EIP) • Standard - DGO - Enterprise Data Governance • LA-Compliance Training • Medicaid Subcontractor Procurement and Contracting Policy	
MCE Description of Process: Humana complies with federal and state privacy requirements for medical records and health information by strictly adhering to the standards set forth in 45 CFR Parts 160 and 164, Subparts A and E, and related regulations. Humana appoints a dedicated privacy official responsible for the development and implementation of privacy policies and procedures, as well as a designated contact to address privacy-related complaints and provide information per 45 CFR §164.520. All associates, contractors, and vendors receive comprehensive training on policies regarding protected health information (PHI) to ensure that they handle PHI appropriately in accordance with 45 CFR §164.530. Additionally, Humana maintains robust administrative, technical, and physical safeguards to protect the privacy and security of PHI, as required by 42 CFR §438.224, 42 CFR §457.1110, and MCO Contract 6.22. These measures collectively ensure that individually identifiable health information is used and disclosed only as permitted by applicable laws and regulations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Use and Disclosure of PHI		
5. The MCE and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCE is permitted to use or disclose PHI as follows: a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCE has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1-3) 45 CFR §164.502(a)(5)(i) 45 CFR §164.502(b) 45 CFR §164.506 45 CFR §164.508 45 CFR §164.510 45 CFR §164.512 45 CFR §164.514(d-g)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement **Evidence as Submitted by the MCE:** • S2_5.1_Disclosure of Protected Health Information, pages 2-7 • S2_5.2_2024 Ethics & Compliance Training, pages 104-106 • S2_5.3_Potential Vendor BAA, entire document • S2_5.4_OB BAA example, entire document **Additional Documentation:** • Potential Privacy or PHI Breach Overview SOP • Documents Received in Error SOP	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.530(c)(2)(ii) 42 CFR §457.1110(a-b) 45 CFR §160 Subpart C MCO Contract: 6.22; 6.23 PAHP Contract: 2.1.4.1; 2.1.4.2 PIHP Contract: 20.12.2		
MCE Description of Process: Humana and its business associates adhere strictly to the requirements set forth by 45 CFR §164.502 and 45 CFR §160 subpart C regarding the use and disclosure of protected health information (PHI). PHI may only be used or disclosed as explicitly permitted or required by these regulations, including disclosures to the individual, for treatment, payment, or health care operations. Additional disclosures are allowed if made pursuant to a valid authorization under agreements or circumstances as otherwise permitted. These practices ensure compliance with federal privacy regulations and safeguard the confidentiality and security of PHI.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the MCE's compliance with 45 CFR §160 subpart C. 45 CFR §164.502(a)(2-4) 45 CFR §164.524 45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C MCO Contract: 6.23 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement **Evidence as Submitted by the MCE:** • S2_6.1_Disclosure of Protected Health Information, pages 6-7 • S2_6.2_2024 Ethics & Compliance Training, page 105-106 • S2_6.2_LA Contract Training, pages 36-37 • S2_6.3_Potential Vendor BAA, entire document • S2_6.4_OB BAA example, entire document	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana and its business associates comply with federal regulations by disclosing protected health information (PHI) as required under specific circumstances. PHI must be disclosed to individuals upon request; additionally, PHI is disclosed when required by the Secretary of Health and Human Services for the purpose of investigating or determining compliance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Minimum Necessary		
7. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCE makes reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Three examples of requests for PHI from another covered entity (e.g., member's previous MCE, dental benefits administrator, provider) **Evidence as Submitted by the MCE:** • S2_7.1_Disclosure of Protected Health Information, page 34 • S2_7.2_2024 Ethics & Compliance Training, page 105 • S2_7.3_2024_Medical Records 1 of 3, entire document • S2_7.3_2024_Medical Records 2 of 3, entire document • S2_7.3_2024_Medical Records 3 of 3, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures compliance with the minimum necessary standard when using, disclosing, or requesting Protected Health Information (PHI) by making reasonable efforts to limit PHI to only what is needed to accomplish the intended purpose.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Policies and procedures are implemented to restrict access to PHI based on job responsibilities and the specific requirements of each request or disclosure.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a). f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. 45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • S2_8.1_Disclosure of Protected Health Information, pages 34-35 • S2_8.2_2024 Ethics & Compliance Training, page 105	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana adheres to the HIPAA minimum necessary standard by limiting the use, disclosure, and request of Protected Health Information (PHI) to the minimum amount necessary to accomplish the intended purpose. However, this requirement does not apply in certain situations, such as disclosures to or requests by a health care provider for treatment, uses or disclosures made directly to the individual, those made pursuant to an authorization, disclosures to the Secretary of Health and Human Services for compliance and		

<table>
<tr><th colspan="3">Standard II—Member Rights and Confidentiality</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">investigations, uses or disclosures required by law, and uses or disclosures required for compliance with applicable HIPAA requirements. These exceptions ensure that critical care, patient rights, legal obligations, and regulatory compliance are not hindered by the minimum necessary standard. Humana’s practices align with these exceptions as outlined in federal regulations.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td colspan="3">Use and Disclosures Requiring Authorizations</td></tr>
<tr><td rowspan="2">9. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization.
a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization.
45 CFR §164.508(a)(1)
45 CFR §164.508(b)(1-6)
45 CFR §164.508(c)(1-4)
45 CFR Part 164 Subpart E
42 CFR §457.1110
MCO Contract: HIPAA Business Associate Provisions
PAHP Contract: HIPAA Business Associate Addendum
PIHP Contract: HIPAA Business Associate Addendum</td><td>HSAG Required Evidence:
• Policies and procedures
• Staff training materials
• Authorization for use and disclosure form template
• Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S2_9.1_Corporate Consent, page 4
• S2_9.2_2024 Ethics & Compliance Training, page 106
• S2_9.3_Consent for Release of PHI, entire document
• S2_9.4_Example Narrative, entire document</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana adheres to federal regulations by requiring a valid authorization before using or disclosing Protected Health Information (PHI), except in circumstances permitted or required by 45 CFR Part 164 Subpart E. When a valid authorization is obtained, Humana ensures that any use or disclosure of PHI is strictly consistent with the terms of that authorization.</td></tr>
</table>

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Privacy Rights		
10. The MCE complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form for privacy protection • Two examples of member's request for privacy protection, including documentation of the request and evidence to support completion of the privacy protection request **Evidence as Submitted by the MCE:** • S2_10.1_Privacy–Individual Rights, pages 3, 9-10 • S2_10.2_2024 Ethics & Compliance Training, page 103,106 • S2_10.3_WF Restriction Request Workflow, entire document • S2_10.4_Form Restriction, entire document • S2_10.5_Mbr Requests Examples, entire document **Additional Documentation:** • Public Website - Notice of Privacy Practices	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana complies with members' rights to request privacy protection for Protected Health Information (PHI) in accordance with 45 CFR §164.522 by maintaining formal policies and procedures that address individual privacy requests. Upon receiving a request, Humana verifies the identity of the requester and assesses whether the request pertains to PHI covered by HIPAA or state-specific regulations. The company processes requests for restriction of use and disclosure, as well as for confidential communications, and accommodates them as required by law. All actions taken are documented, and Humana communicates outcomes to the requester in a timely manner, ensuring compliance with federal regulations and internal guidelines.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The MCE complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The MCE acts on a request for access no later than 30 days after receipt of the request. b. The MCE provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCE and member. 45 CFR §164.524 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form to access PHI • Two examples of member's request to access PHI, including documentation of the request and evidence to support timely completion of the PHI access request **Evidence as Submitted by the MCE:** • S2_11.1_Privacy–Individual Rights, Pages 3, 11-14 • S2_11.2_Member Rights & Responsibilities, page 15 • S2_11.3_WF Access Request, entire document • S2_11.4_Form Access, entire document • S2_11.5_Mbr Requests Examples, entire document	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures compliance with 45 CFR §164.524 by processing member requests for access to protected health information (PHI) promptly and within regulatory timeframes. Upon receiving a request, Humana acts within 30 days to either provide the requested PHI or notify the member of any necessary extension. Members are given access to their PHI in the format they request, provided it is readily producible; if not, the information is supplied in a readable hard copy or another agreed-upon format.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. The MCE complies with the member's right to have the MCE amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCE complies with the requirements under 45 CFR §164.526. • The MCE acts on the member's request for an amendment no later than 60 days after receipt of such a request. 45 CFR §164.526 42 CFR §457.1110(e) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form to amend PHI • Two examples of member's request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request • One example of a denial of an amendment and notification to the member **Evidence as Submitted by the MCE:** • S2_12.1_Privacy–Individual Rights, pages 3, 15-16 • S2_12.2_Privacy–Individual Rights, pages 3 • S2_12.2_LA Contract Training, page 36 • S2_12.3_WF Amendment Request, entire document • S2_12.4_PHI Request Form, entire document • S2_12.5_Mbr Requests Examples, entire document • S2_12.6_Denied Example, entire document	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard II—Member Rights and Confidentiality</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCE Description of Process: Human fully adheres to 45 CFR §164.526 by respecting a member’s right to request an amendment to their Protected Health Information (PHI) or any record maintained in a designated record set. Upon receiving a member’s request for amendment, the Humana takes timely action, ensuring the request is processed within 60 days as required by federal regulations. This process demonstrates Humana’s commitment to maintaining accurate and complete records, as well as safeguarding members’ privacy rights in accordance with regulatory standards.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">13. The MCE complies with the member’s right to receive an accounting of disclosures of PHI made by the MCE in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528.
a. The MCE acts on the member’s request for an accounting, no later than 60 days after receipt of such a request.
b. The MCE documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j).
45 CFR §164.528
45 CFR §164.530(j)
42 CFR §457.1110
MCO Contract: HIPAA Business Associate Provisions
PAHP Contract: HIPAA Business Associate Addendum
PIHP Contract: HIPAA Business Associate Addendum</td><td>HSAG Required Evidence:
• Policies and procedures
• Staff training materials
• Process workflow
• Member request form for an accounting of disclosures of PHI
• Mechanism to track disclosures (e.g., where reports to Adult Protective Services are documented within the system for retrieval for the accounting of disclosure)
• Two examples of member’s request for an accounting of disclosures, including documentation of the request and evidence to support timely completion of the accounting of disclosure request
• Documentation to demonstrate how the record of the accounting of disclosures is retained</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S2_13.1_LA Privacy Policy Summary, page 5</td></tr>
</table>

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• S2_13.1_Privacy–Individual Rights, pages 3, 9, 16 • S2_13.2_2024 Ethics & Compliance Training, page 105 • S2_13.3_WF Accounting of Disclosures, entire document • S2_13.4_Form Accounting of Disclosures, entire document • S2_13.5_Accounting of Disclosures, page 5 • S2_13.6_Mbr Requests Examples, entire document • S2_13.7_Accounting of Disclosures, pages 1-5	
MCE Description of Process: Humana complies with members' rights under 45 CFR §164.528 by providing an accounting of disclosures of Protected Health Information (PHI) made in the six years preceding a member's request. Upon receipt of such a request, Humana responds by ensuring the accounting is provided within 60 days.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Breach of Unsecured PHI		
14. The MCE, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCE to have been accessed, acquired, used, or disclosed as a result of such breach.	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
a. Breach and unsecured PHI are as defined in 45 CFR §164.402. 45 CFR §164.402 45 CFR §164.404(a)(1) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• List of all breaches of unsecured PHI during the time period under review, including the date of discovery and the date of notification to members **Evidence as Submitted by the MCE:** • S2_14.1_Investigation and Resolution Government Humanas, page 3 • S2_14.2_Breach Notification Template, entire document • S2_14.3_Incident Risk Assessment Tool, entire document • S2_14.3_Privacy Risk Assessment, page 1 • S2_14.3_Investigation and Resolution Government Humanas, pages 2-3 • S2_14.4_RADAR Incident System, entire document • S2_14.5_Narrative, entire document	
MCE Description of Process: Upon discovery of a breach of unsecured PHI as defined under 45 CFR §164.402, Humana initiates a thorough investigation following established procedures. The Privacy Office documents the incident in the RADAR incident management system, assesses the risk and scope, and determines the individuals affected. Each impacted individual is notified without unreasonable delay, and in no case later than 60 calendar days after the breach is discovered. The notification includes details about the breach, the information involved, actions taken by Humana, and steps individuals can take to protect themselves.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
15. The MCE for the purposes of 45 CFR §164.404(a)(1), 45 CFR §164.406(a), and 45 CFR §164.408(a), a breach is treated as discovered by the MCE as of the first day on which such breach is known to the MCE, or, by exercising reasonable diligence would have been known to the MCE. a. The MCE shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the MCE. 45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • List of all breaches of unsecured PHI during the time period under review, including the date of discovery **Evidence as Submitted by the MCE:** • S2_15.1_Investigation and Resolution Government Humanas, page 1 • S2_15.2_Investigation and Resolution Government Humanas, pages 2-3, 6-8 • S2_15.2_RADAR Incident System, entire document • S2_15.3_RADAR Incident System, entire document • S2_15.4_Narrative, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: It is Humana's policy to respond to a breach of unsecured PHI on the first day it is known or would have been known by exercising reasonable diligence.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
16. Except as provided in 45 CFR §164.412, the MCE must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach. 45 CFR §164.404(b) 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • List of all breaches of unsecured PHI during the time period under review, including the date of discovery and date of notification to members • Three examples of breach notification letters to members **Evidence as Submitted by the MCE:** • S2_16.1_Investigation and Resolution Government Humanas, page 2 • S2_16.2_Narrative, entire document • S2_16.3_Breach Notification Letter, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures compliance with federal regulations by providing notification to affected individuals without unreasonable delay and no later than 60 calendar days after the discovery of a breach. Upon identifying a privacy incident, Humana promptly investigates the event, determines the information involved, and takes corrective measures to prevent recurrence. Notification letters are sent to impacted members, clearly explaining what happened, what information was involved, the steps Humana has taken, and guidance on what members can do.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible:	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Reading grade level of breach notification letter template	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). c. Any steps individuals should take to protect themselves from potential harm resulting from the breach. d. A brief description of what the MCE is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address. 45 CFR §164.404(c) 45 CFR §164.406(c) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• Three examples of breach notification letters to members • One example of notification to media outlet, if applicable during the review period **Evidence as Submitted by the MCE:** • S2_17.1_Data Breach Notification, entire document • S2_17.2_Reading Grade Level, entire document • S2_17.3_Breach Notification Letter, entire document • S2_17.4_Narrative, entire document	
MCE Description of Process: Humana's notification process ensures that individuals are promptly informed in writing, using clear and plain language, when a breach of unsecured protected PHI occurs. Each notification includes a concise description of the incident, specifying both the date the breach occurred and the date it was discovered, when available. The letter details the types of PHI involved, such as names, claim information, provider details, or other relevant data, and outlines recommended steps that individuals can take to safeguard themselves. Humana also describes the corrective actions taken to investigate the breach, mitigate potential harm, and prevent future occurrences, such as changing processes or enhancing quality checks. Finally, the notification provides multiple contact methods—including a toll-free telephone number and, where appropriate, an email address—for affected individuals to obtain additional information or assistance.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
18. The notification must be provided in the following form: a. Written notice by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. b. If the MCE knows the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to either the next of kin or personal representative of the individual. c. The notification may be provided in one or more mailings as information is available. 45 CFR §164.404(d)(1) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Confirmation of first-class mailing **Evidence as Submitted by the MCE:** • S2_18.1_Investigation and Resolution Government Humanas, pages 2-3 • S2_18.2_Investigation and Resolution Government Humanas, pages 2	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that breach notifications are provided to affected individuals in accordance with regulatory requirements. Written notice is sent by first-class mail to the individual's last known address, or by electronic mail if the individual has consented to this method and has not withdrawn consent. In cases where the individual is known to be deceased and contact information for the next of kin or a personal representative is available, written notification is sent by first-class mail to that party. Notifications may be sent in one or more mailings as new information becomes available.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
19. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual must be provided. a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be provided by an alternative form of written notice, telephone, or other means. b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must: i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the MCE's website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured PHI may be included in the breach. c. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under 45 CFR §164.404(d)(1)(ii). 45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • One example of a substitute notice for when there was insufficient or out-of-date contact information for fewer than 10 members, if applicable during the review period • One example of a substitute notice for when there was insufficient or out-of-date contact information for more than 10 members, if applicable during the review period **Evidence as Submitted by the MCE:** • S2_19.1_Investigation and Resolution Government Humanas, page 3 • S2_19.2_Breach Notification Letter, entire document • S2_19.2_Substitute Notice, entire document • S2_19.3_Data Breach Notification, entire document • S2_19.3_Substitute Notice, entire document	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana complies with the requirements for substitute notice when there is insufficient or out-of-date contact information to provide written notification to individuals affected by a breach of unsecured PHI. If fewer than 10 individuals are affected, Humana provides a substitute notice through an alternative form of written notice, telephone, or other reasonable means. When 10 or more individuals are impacted and cannot be reached, Humana provides substitute notice either by posting a conspicuous notice for at least 90 days on the home page of Humana's website or by publishing a notice in major print or broadcast media in the in geographic areas where the individuals affected by the breach likely reside This notice includes a toll-free phone number that remains active for at least 90 days for individuals to inquire whether their PHI was involved in the breach.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
20. In any case deemed by the MCE to require urgency because of possible imminent misuse of unsecured PHI, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1). 45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • One example of notice provided to members for an urgent situation, if applicable during the review period **Evidence as Submitted by the MCE:** • S2_20.1_Investigation and Resolution Government Humanas, page 2 • S2_20.2_Narrative, entire document • S2_20.2_Data Breach Notification, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: In situations where there is a potential for imminent misuse of unsecured PHI, Humana follows established procedures to promptly notify affected individuals. In addition to the standard written notification required under 45 CFR §164.404(d)(1), Humana may provide urgent notification by telephone. This process includes using the Government Humana Member Outbound Call Script template for outbound calls, obtaining necessary approvals, and documenting all actions taken.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
21. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the MCE must, following the discovery of the breach, notify prominent media outlets serving the State or jurisdiction, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. 45 CFR §164.404(c) 45 CFR §164.406(a-b) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • One example of breach of unsecured PHI involving more the 500 members, including the date of discovery and date of notification to media outlets, if applicable during the review period **Evidence as Submitted by the MCE:** • S2_21.1_Investigation and Resolution Government Humanas, pages 4,8 • S2_21.2_Narrative, entire document **Additional Documentation:** • 22.1_Breach of Unsecured PHI	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: When a breach of unsecured protected health information (PHI) impacts more than 500 residents of a state or jurisdiction, Humana's policy requires notification of prominent media outlets serving that area without unreasonable delay and no later than 60 calendar days after the breach is discovered. The Privacy Office conducts a thorough investigation, documents all pertinent information in the tracking database, and, upon confirming the breach meets the reporting threshold, coordinates with management to prepare the media notification.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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<tr><th colspan="3">Standard II—Member Rights and Confidentiality</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>22. The MCE must, following the discovery of a breach of unsecured PHI, notify the Secretary.
a. For breaches of unsecured PHI involving 500 or more individuals, the MCE must, except as provided in 45 CFR §164.412, provide the notification contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the Department of Health and Human Services (HHS) Web site.
b. For breaches of unsecured PHI involving less than 500 individuals, the MCE must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS web site.
45 CFR §164.404(a)
45 CFR §164.408
45 CFR §164.412
MCO Contract: HIPAA Business Associate Provisions
PAHP Contract: HIPAA Business Associate Addendum
PIHP Contract: HIPAA Business Associate Addendum</td><td>HSAG Required Evidence:
• Policies and procedures
• List of breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members
• Annual notification to HHS of breaches of unsecured PHI, including the date of notification
Evidence as Submitted by the MCE:
• S2_22.1_Breach of Unsecured PHI, pages 2-3
• S2_22.2_Narrative, entire document
• S2_22.3_Annual notification of breaches, entire document
• S2_22.3_ Annual Breach Report, entire document</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana complies with federal regulations regarding breach notification to the Secretary of Health and Human Services (HHS) as outlined in its policies and procedures. For breaches of unsecured PHI involving 500 or more individuals, Humana provides notification to HHS contemporaneously with individual notifications. For breaches impacting fewer than 500 individuals, Humana maintains a detailed log of such incidents and submits an annual report to HHS. The Privacy Office oversees the review, approval, and timely submission of all breach notifications.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
</table>

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
23. The MCE must require its business associates (i.e., subcontractors) to, following the discovery of a breach of unsecured PHI, notify the MCE of such breach. a. A breach shall be treated as discovered by a business associate as of the first day on which such breach is known to the business associate or, by exercising reasonable diligence, would have been known to the business associate. A business associate shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the business associate. b. Except as provided in 45 CFR §164.412, the MCE must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. c. The notification must include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach. d. The MCE must require a business associate to provide the MCE with any other available information that the MCE is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available. 45 CFR §164.404(c)	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI reported by subcontractors • One example of executed business associate agreement • One example of executed subcontractor contract **Evidence as Submitted by the MCE:** • S2_23.1_Business Associate Agreement Policy, page 2 • S2_23.1_Business Associate Agreement Template, pages 3-4 • S2_23.2_Narrative, entire document • S2_23.3_OB BAA Example, entire document • S2_23.4_OB BAA Example, entire document	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.410 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum		
MCE Description of Process: Humana's Business Associate Agreement requires all business associates and subcontractors to promptly notify Humana upon discovery of any breach of unsecured PHI. A breach is considered discovered as of the first day it is known to the business associate, or would have been known with reasonable diligence, including knowledge held by any employee, officer, or agent other than the individual committing the breach. Notification to Humana must be made without unreasonable delay and no later than 60 calendar days after discovery. The notification must, to the extent possible, identify each individual whose unsecured PHI was, or is reasonably believed to have been, involved in the breach, and provide any additional information required for Humana's notification obligations. These requirements are explicitly outlined in Section 3(l) of the Humana HIPAA Business Associate Agreement.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Notice of Privacy Practices		
24. The MCE's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCE, and of the member's rights and the MCE's legal duties with respect to PHI. a. The MCE provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1). b. The MCE makes the notice available to its members on request as required by 45 CFR §164.520(c). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110	**HSAG Required Evidence:** • Policies and procedures • Process for disseminating Notice of Privacy Practices • Staff training materials • Copy of Notice of Privacy Practices • Link to Notice of Privacy Practices on the MCE's website **Evidence as Submitted by the MCE:** • S2_24.1_Notice of Privacy Practices, pages 1-5 • S2_24.2_Notice of Privacy Practices, page 5	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• S2_24.3_Member Rights & Responsibilities, pages 15,17 • S2_24.4_Notice of Privacy-Span, entire document • S2_24.4_Notice of Privacy-Eng, entire document • S2_24.5_Link to Privacy Practices, entire document	
MCE Description of Process: Humana ensures that its members receive adequate notice regarding the uses and disclosures of PHI and their related rights. The Notice of Privacy Practices is written in clear, plain language and details how PHI may be used and disclosed, the member's rights with respect to their information, and Humana's legal duties to protect that information. This notice is readily available to all members upon request, both in print and online. Members are informed of their right to obtain a copy at any time by contacting Humana or accessing the company's website.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard II—Member Rights and Confidentiality							
Total	Met	=	24	X	1	=	24
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	24	**Total Score**		=	24

Total Score ÷ Total Applicable	=	**100%**

Member Rights Checklist

Standard II—Member Rights Checklist		
	Required Components	
A member enrolled with the MCE has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; 2.14.8; MCO Manual PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.13.1.1.2	1. Receive information in accordance with 42 CFR §438.10. **Evidence as submitted by the MCE:** • C2a_1_Enrollee Communications, pages 1-2 • C2a_1_Member Handbook, pages 62-63 • In virtual review, staff described that the welcome kit informs members to request materials in particular formats (also in handbook and website). Member services can access member profile which documents preferred format which is housed in customer management system (ensuring materials are distributed in preferred format/language).	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.3	2. Be treated with respect and with due consideration for his or her dignity and privacy. **Evidence as submitted by the MCE:** • C2a_2_Member Handbook, page 7 **Additional Documentation:** • Member services audit procedure • Member survey (follow up on calls that members expressed dissatisfaction)	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220 MCO Contract: 2.13.1.4.6; 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.4	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. **Evidence as submitted by the MCE:** • C2a_3_Member Handbook, page 7 **Additional Documentation:** • SOP for provider onboarding • Provider Manual, page	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
	Required Components	
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220 MCO Contract: 2.9.32.1.4; 2.13.6.2.6; MCO Manual PAHP Contract: 2.6.9.5.1.4 PIHP Contract: 5.13.1.1.6	4. Participate in decisions regarding his or her health care, including the right to refuse treatment. **Evidence as submitted by the MCE:** • C2a_4_Member Handbook, page 7 **Additional Documentation:** • SOP for provider onboarding • Provider Manual, page	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.7	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. **Evidence as submitted by the MCE:** • C2a_5_Member Handbook, page 7 **Additional Documentation:** • SOP for provider onboarding • Provider Manual, page	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(vi) 42 CFR §457.122045 CFR Part 160 45 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526. **Evidence as submitted by the MCE:** • C2a_6_Member Handbook, page 7	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
	Required Components	
MCO Contract: 2.13.6.2.6; 2.13.6.6.3.11; MCO Manual PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: 5.13.1.1.9	**Additional Documentation:** • Additional policies that evidence the MCE's procedures for providing copy/amendments to medical records	
42 CFR §438.100(b)(3) 42 CFR §438.206 through§438.210 42 CFR §457.1220 MCO Contract: 2.4.1.2; 2.13.6.2.6; MCO Manual PAHP Contract: 2.4.1.4; 2.9.1.9 PIHP Contract: 5.13.1.1.14	7. Be furnished health care services in accordance with 42 CFR §438.206 through §438.210. **Evidence as submitted by the MCE:** • C2a_7_Member Handbook, page 7 • Robust network policy **Additional Documentation:** • Policy that describes MCE's robust provider network to ensure it furnishes required services	Y ☒ N ☐ NA ☐
42 CFR §438.100(c) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.15	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE and its network providers or the State treat the member. **Evidence as submitted by the MCE:** • C2a_8_Member Handbook, page 7 **Additional Documentation:** • LA.MAR.037 Enrollee Rights and Responsibilities • Member services audit procedure	Y ☒ N ☐ NA ☐
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80	9. The MCE shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
	Required Components	
45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX ADA, Titles II and III ACA, Section 1557 MCO Contract: 2.13.6.2.6; 6.6.1 PAHP Contract: 6.4 PIHP Contract: 20.3.1	education programs and activities), Titles II and III of the Americans with Disabilities Act (ADA), and section 1557 of the Patient Protection and Affordable Care Act (ACA). **Evidence as submitted by the MCE:** • C2a_9_Member Handbook, page 62 **Additional Documentation:** • LA.MAR.037 Enrollee Rights and Responsibilities • Various training materials and SOPs submitted for other elements	

Standard III—Member Information

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Information Requirements		
1. The MCE provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members. *“Readily accessible” means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.* *Note: LA reading grade level should be no higher than a 6.9 reading grade level for MCOs and PAHPs and no higher than a 5.0 reading grade level for the PIHP.* 42 CFR §438.10(c)(1) 42 CFR §457.1207 MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.8.4.5	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook, provider directory, member notices, etc. • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Proof of website accessibility (e.g., assessment or testing of accessibility features of website and confirmation of 508 compliance) **Evidence as Submitted by the MCE:** • S3_1.1_Narrative, entire document • S3_1.1_Enrollee Communications, pages 1-2 • S3_1.2_2024 Member Handbook, pages 55-56 • S3_1.3_Narrative, entire document • S3_1.4_Humana Louisiana MCD Website Accessibility, entire document **Additional Documentation:** • 3_1_S3_1.1_Narrative	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Humana ensures that all information provided to members and potential members is presented in a clear and understandable manner, with materials consistently reviewed to meet readability standards. Written communications are designed to be easily		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
understood, using language at or below a sixth grade reading level as measured by the Flesch-Kincaid test. All electronic content and services are made readily accessible in accordance with modern accessibility standards. Regular internal quality control reviews help guarantee that materials meet both accessibility and comprehension requirements before distribution.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. During the interview session, HUM staff members confirmed a policy and procedure was not in place during the review time frame to ensure HUM provided all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members.		
Required Actions: The MCE must implement a written process that ensures all required information referenced in 42 CFR §438.10 is provided to members and potential members in a manner and format that may be easily understood and is readily accessible.		
2. The MCE uses the definitions for managed care terminology developed by the State including: a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. 42 CFR §438.10(c)(4)(i) 42 CFR §457.1207 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S3_2.1_Enrollee Communications, page 1 • S3_2.1_Narrative, entire document • S3_2.2_2024 Member Handbook, page 25 • S3_2.2_Narrative, entire document **Additional Documentation:** • 3_2 Narrative	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures that all educational and member-facing materials use managed care terminology as developed by the State, making information clear and consistent for members. The Member Handbook and related communications are carefully reviewed and updated by subject matter experts to incorporate the State's definitions for terms such as grievance, appeal, emergency services, durable medical equipment, and more. These resources are designed to help members understand their benefits and rights, with terminology used in a manner that aligns with State guidelines. Humana regularly reviews and updates materials to ensure continued compliance and clarity for all members.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's member handbook did not utilize definitions that aligned with State definitions.		
Required Actions: The MCE must ensure the use of definitions for managed care terminology developed by the State.		
3. The MCE uses State-developed model member handbooks and member notices. PIHP: a. *The PIHP shall develop and maintain a Member Handbook, due to LDH at go-live, that adheres to the requirements in 42 CFR §438.10 and the written materials requirements.* 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.1	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, grievance and appeal notices (include any other template for all State-required model notices) **Evidence as Submitted by the MCE:** • S3_3.1_Enrollees Rights and Responsibilities, pages 1-2 • S3_3.2_2024 Member Handbook, entire document • S3_3.3_Acknowledgement Letter, entire document • S3_3.3_NABD Letter, entire document • S3_3.3_AOR Request, entire document • S3_3.3_Disenroll Resolution, entire document • S3_3.3_GRV Resolution, entire document	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures compliance by utilizing state-developed model member handbooks and notices as the foundation for all member communications and materials. These documents are carefully tailored to provide clear, consistent information that meets state guidelines and addresses member needs. Humana regularly reviews and updates these materials to reflect current policies, benefits, and services, ensuring members receive accurate and accessible information.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Language and Format		
4. The MCE makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the MCE's member/customer services unit.	**HSAG Required Evidence:** • Policies and procedures • Provider directory in English, including taglines • Provider directory in prevalent non-English languages, including taglines • Member handbook in English, including taglines • Member handbook in prevalent non-English languages, including taglines • Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices) • Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines • Definition of conspicuously visible font • Mechanisms to ensure taglines are included as part of all critical member materials	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. 42 CFR §438.10(d)(3) 42 CFR §457.1207 MCO Contract: 2.13.15.5 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15	**Evidence as Submitted by the MCE:** • S3_4.1_Alternate Versions of Fulfilment, pages 1-2 • S3_4.2_2024 Provider Directory, entire document • S3_4.3_2024 Provider Directory, entire document • S3_4.4_2024 Member Handbook, entire document • S3_4.5_Spanish Member Handbook, entire document • S3_4.6_LA Appeal Resolution, entire document • S3_4.6_GRV Resolution, entire document • S3_4.6_NABD Letter, entire document • S3_4.7_LA Appeal Resolution SP, entire document • S3_4.7_GRV Resolution SP, entire document • S3_4.7_NABD Letter, entire document • S3_4.8_Brand Supplement Guide-Jan2024, page 25 • S3_4.9_Brand Supplement Guide-Jan2024, page 49	
MCE Description of Process: Humana ensures that all written materials essential for accessing services, such as provider directories, member handbooks, and notices regarding appeals, grievances, denials, and terminations, are available in the prevalent non-English languages spoken in its service areas. These materials are also provided in alternative formats, including large print, braille, or audio, at no cost upon request to meet the diverse needs of members and potential members. Each document contains taglines in the prevalent non-English languages of the State, presented in a highly visible font, to inform readers about the availability of translation and interpretation services. Additionally, all critical written materials include clear instructions on how to request auxiliary aids and services, as well as prominently displayed toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) contact numbers for member services. Auxiliary aids and services are offered free of charge to ensure that information is accessible to all individuals, regardless of language or disability.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE makes interpretation services available to each member free of charge. a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL). b. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent. 42 CFR §438.10(d)(4) 42 CFR §457.1207 MCO Contract: 2.13.15.2 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1	**HSAG Required Evidence:** • Policies and procedures • Executed interpretation services (oral and written) contract(s) • Workflow for obtaining oral interpretation services **Evidence as Submitted by the MCE:** • S3_5.1_Alternate Versions of Fulfilment, entire document • S3_5.2_Braillet Corporation BAA, entire document • S3_5.2_Voiance Inc. Amendment, entire document • S3_5.3_Over the Phone Interpretation, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana provides interpretation services to all members at no cost, ensuring access to oral interpretation and auxiliary aids such as TTY/TDD and American Sign Language. Services are available for a minimum of 150 languages, not limited to those identified as prevalent in the State, and can be accessed 24 hours a day, seven days a week. Members can request interpretation through the Member Call Center, and arrangements are made promptly for both spoken and sign language needs. Additionally, Humana offers these services to support members with disabilities, ensuring equal access to information and healthcare services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
6. The MCE notifies members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access these services. 42 CFR §438.10(d)(5) 42 CFR §457.1207 MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • S3_6.1_Alternate Versions of Fulfilment, entire document • S3_6.2_2024 Member Handbook, page 17	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana informs members that oral interpretation services are available for any language and that written materials can be provided in prevalent non-English languages. Members are also notified that auxiliary aids and services, such as sign language interpreters and materials in alternative formats, are available at no cost for individuals with disabilities. This information is included in member handbooks and other critical communications, along with clear instructions on how to access these services. Members may request assistance by contacting Member Services at the toll-free number provided, and Humana ensures prompt support to meet individual language and accessibility needs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. The MCE provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an	**HSAG Required Evidence:** • Policies and procedures • Member handbook • Provider directory • All member newsletters during the time period of review	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. *"Limited English proficient (LEP)" means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.* 42 CFR §438.10(d)(6) 42 CFR §457.1207 MCO Contract: 2.14.8; 2.14.8.1; 2.14.8.8 PAHP Contract: 2.9.2.1.3.2.3; 2.9.2.1.3.2.4 PIHP Contract: 5.6.1.1; 5.6.1.3	• Member notices (in Microsoft Word), including an ABD notice, grievance resolution notice, and appeal resolution notice • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services **Evidence as Submitted by the MCE:** • S3_7.1_Brand_Supplement_Guide-Jan2024, page 25,49 • S3_7.2_2024 Member Handbook, pages 66-67 • S3_7.3_2024_Provider Directory, pages 6, 10-11 • S3_7.4_Q1 ENT Newsletter, entire document • S3_7.4_Q2 Member Newsletter, entire document • S3_7.4_Q3 Member Newsletter, entire document • S3_7.4_ Q4 Member Newsletter, entire document • S3_7.5_LA Appeal Resolution, entire document • S3_7.5_NABD Letter, entire document • S3_7.5_GRV Resolution, entire document • S3_7.6_Narrative, entire document • S3_7.7_Narrative, entire document	

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• S3_7.7_Voiance Call Detail Report 2024, entire document • S3_7.8_Voiance Call Detail Report 2024, entire document **Additional Documentation:** • 3_7_Appeal Resolution Letter • 3_7_Grievance Resolution Letter	
MCE Description of Process: Humana ensures all written materials for potential members and members are developed using clear, easily understood language and presented in a straightforward format. All communications are produced in at least 12-point font to support readability. Materials are reviewed by a team of copywriters, editors, and business experts to confirm accessibility and comprehension, with reading levels kept at or below sixth grade using the Flesch–Kincaid readability test. Additionally, Humana makes these materials available in alternative formats and provides auxiliary aids and services, such as large print, braille, and qualified sign language interpreters, to meet the needs of individuals with disabilities or limited English proficiency. Language assistance services are offered free of charge for those who do not speak English as their primary language.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Information for Members		
8. The MCE makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of: a. Thirty calendar days prior to the effective date of the termination; or	**HSAG Required Evidence:** • Policies and procedures • Workflow of provider termination process • Two examples of MCE-initiated provider terminations, including evidence of the effective date of the termination and the notice sent to affected members	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
b. Fifteen calendar days after receipt or issuance of the termination notice. PAHP: a. The PAHP shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. 42 CFR §438.10(f)(1) 42 CFR §457.1207 MCO Contract: 2.13.9.2 PAHP Contract:2.6.11.4 PIHP Contract: 5.14.1.2	• Two examples of provider-initiated terminations when the effective date of the termination is in the future, including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members • Two examples of provider-initiated terminations when the effective date of the termination has passed (i.e., retroactive termination), including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members • Tracking or reporting mechanism that demonstrates timeliness	
	Evidence as Submitted by the MCE: • S3_8.1_Network Provider Terminations, pages 1,4 • S3_8.2_Network Provider Terminations, pages 4, 6-7 • S3_8.3_Narrative, entire document • S3_8.3_Term_Ron T Dantin, entire document • S3_8.3_Term_Scharmaine Baker, entire document • S3_8.4_Narrative, entire document • S3_8.5_Term Notification 1, entire document • S3_8.5_Term Notification 2, entire document • S3_8.5_Term Email, entire document • S3_8.6_LA MCD Metric Report_2024, entire document	

<table>
<tr><th colspan="3">Standard III—Member Information</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td></td><td>Additional Documentation:
• 3_8_Narrative</td><td></td></tr>
<tr><td colspan="3">MCE Description of Process: Humana follows a structured process to ensure that members are promptly informed if their primary care provider or regularly seen provider is terminated from the network. Written notices are prepared to be sent to affected members either thirty days before the provider's termination or within fifteen days of receiving or issuing the termination notice, whichever is later. In recent examples, Humana documented provider terminations and confirmed that there were no members requiring notification, as no members were assigned or regularly seen by those providers.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">9. The MCE makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i).
42 CFR §438.3(i)
42 CFR §438.10(f)(3)
42 CFR §457.1207
MCO Contract: 2.17.4.5
PAHP Contract: None
PIHP Contract: 20.41.1</td><td>HSAG Required Evidence:
• Policies and procedures
• List of physician incentive plans
• Example of physician incentive plan provided to a member upon request (if the MCE does not have physician incentive plans, please state so under the MCE Description of Process)</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S3_9.1_Enrollees Rights and Responsibilities, page 1
• S3_9.2_List of Physician Incentive Plans, entire document
• S3_9.3_Narrative, entire document</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures transparency by making information about physician incentive plans available to members upon request. The organization maintains a list of current value-based provider incentive programs, such as Care Coordination Fees, Access Fees, Quality Plus, Model Practice, Medical Home, and Maternity Quality Rewards, which are designed to support quality care and positive</td></tr>
</table>

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
health outcomes. As of December 31, 2024, this information is kept up to date and accessible, even though there have been no member inquiries to date. This process demonstrates Humana's commitment to keeping members informed about physician incentive arrangements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Member Handbook		
10. The member handbook is provided to the member within a reasonable time frame. The member handbook is considered provided if the MCE: a. Mails a printed copy of the information to the member's mailing address; b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the MCE's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. PAHP: a. The PAHP shall furnish the following materials within ten (10) business days following receipt of the member	**HSAG Required Evidence:** • Policies and procedures • Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.) • Member materials, such as member welcome packet • Tracking mechanism for mailings of the member handbook or welcome notice, and the date of the notice to the member **Evidence as Submitted by the MCE:** • S3_10.1_Enrollees Rights and Responsibilities, page 2 • S3_10.2_Enrollees Rights and Responsibilities, page 2 • S3_10.2_Member Handbook Webpage, entire document • S3_10.2_Request for Member Materials, page 3-4 • S3_10.3_Narrative, entire document	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard III—Member Information</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>file to each person who is newly enrolled or re-enrolled:
i. A current enrollee handbook
42 CFR §438.10(g)(1)
42 CFR §438.10(g)(3)
42 CFR §457.1207
MCO Contract: 2.13.6.3
PAHP Contract: 2.9.7.2; 2.9.8.1; 2.9.8.1.2
PIHP Contract: 5.8.3.3</td><td>• S3_10.3_Postcard, page 1
• S3_10.3_2024 Welcome Booklet, page 5,7, 15-16
• S3_10.4_Narrative, entire document
• S3_10.4_Welcome Kit Fulfillment, page 1</td><td></td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures members receive the member handbook promptly by offering multiple methods of delivery. Printed copies are mailed to the member’s address, and the handbook can also be provided by email with the member’s prior consent. Additionally, the handbook is available on the organization’s website, with members notified through paper or electronic communications that include the internet address. For members who are unable to access the handbook online due to a disability, auxiliary aids and services are provided upon request at no cost. These processes are closely monitored through a tracking mechanism that verifies timely delivery and compliance with all applicable guidelines.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">11. The member handbook includes all requirements listed in the Member Handbook Checklist.
42 CFR §438.10(g)(2)
42 CFR §457.1207
MCO Contract: 2.13.6.2
PAHP Contract: 2.9.7.2
PIHP Contract: 5.8.3.3</td><td>HSAG Required Evidence:
• Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested)
• Link to member handbook on MCE’s website
• HSAG will also use the results of the Member Handbook Checklist</td><td rowspan="2">☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S3_11.1_2024 Member Handbook, entire document
• S3_11.2_Link to Member Handbook, entire document</td></tr>
</table>

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • 3_11_Member Handbook English	

MCE Description of Process: The Humana Healthy Horizons in Louisiana Member Handbook addresses all elements outlined in the Member Handbook Checklist. It offers clear explanations of benefits, member rights and responsibilities, procedures for accessing care, and information on grievance and appeal processes. The handbook also includes details on coverage, coordination of care, privacy protections, and instructions for obtaining services in alternative formats or languages. Contact information for Member Services and additional resources is provided to ensure members can access support and information as needed.

HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's member handbook did not include the following:

- Language that states the time frame for filing a grievance;
- Instructions, in Spanish, on how a member can access auxiliary aids and services, including additional information in alternative formats; and
- Information regarding specialized behavioral health services, including:
  - General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; and
  - Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families.

Required Actions: The MCE must revise the member handbook to include the following:

- Language that states the time frame for filing a grievance;
- Instructions, in Spanish, on how a member can access auxiliary aids and services, including additional information in alternative formats; and
- Information regarding specialized behavioral health services, including:
  - General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; and
  - Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families.

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
12. The MCE gives each member notice of any change to the member handbook that the State defines as significant in the information specified in the member handbook, at least 30 days before the intended effective date of the change. *Note: LA defines significant as "important in effect or meaning."* 42 CFR §438.10(g) 42 CFR §457.1207 MCO Contract: 2.13.2.3 PAHP Contract: 2.9.7.2; 2.9.8.4.1 PIHP Contract: 5.8.3.3	**HSAG Required Evidence:** • Policies and procedures • Workflow for member handbook changes • One example of a change to the member handbook due to a significant change and notice sent to members (if there were no significant changes during the past 12 months, state so in the *MCE Description of Process*) • Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change, and the date members were notified **Evidence as Submitted by the MCE:** • S3_12.1_Narrative, entire document • S3_12.2_Process Flow, pages 2,6 • S3_12.3_Narrative, entire document • S3_12.4_Narrative, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana has a process in place to notify members of any significant changes to the member handbook, ensuring that notices are sent at least 30 days before the change takes effect, in accordance with state requirements. While there were no significant changes requiring notification in 2024, the organization outlined its procedures for timely communication. Member notifications are processed through a coordinated effort between the print management and communications teams, using a tracking system to verify mailing dates and compliance. Any discrepancies identified in the notification process are promptly investigated and corrected to maintain accuracy and timeliness.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Provider Directory		
13. The MCE makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 MCO Contract: 2.13.6.4 PAHP Contract: 2.9.8.3.1; 2.9.8.1.4 PIHP Contract: 5.8.3.1; 5.10.1	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory (e.g., bulk printing, print on demand) • Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable) • Link to the online provider directory • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the MCE:** • S3_13.1_Enrollees Rights and Responsibilities, page 2 • S3_13.2_2024 Louisiana Online Provider Finder Tool, entire document • S3_13.2_2025 Louisiana Online Provider Finder Tool, entire document • S3_13.3_2024 Provider Directory, entire document • S3_13.4_Link to Provider Directory, entire document • S3_13.5_Louisiana Online Provider Finder Tool, page 1 **Additional Documentation:** • 3_13_Narrative	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures that provider directories are accessible to members and prospective members both electronically and in paper form upon request. The electronic directory is updated daily and is available to the public on the Humana website without requiring an account, offering comprehensive, searchable information as outlined in the Provider Directory Checklist. Members may request a printed copy, which is mailed within five business days at no cost, and the printed directories are updated at least monthly to ensure accuracy. Both formats include details such as provider names, contact information, specialties, office accessibility, languages spoken, and other key attributes relevant to selecting providers.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's electronic directory did not include the provider's website uniform resource locator (URL). **Recommendations:** HSAG recommends that the MCE ensure its public, searchable provider directory is updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).		
Required Actions: The MCE must ensure the provider directory includes the provider's URL, if appropriate.		
14. Information included in the MCE's paper provider directory is updated at least: a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or b. Quarterly, if the MCE has a mobile-enabled electronic provider directory. PAHP: a. *The PAHP shall update the printable version of the provider directory at least quarterly and include versioning.* 42 CFR §438.10(h)(3)(i) 42 CFR §457.1207 MCO Contract: 2.13.8.4; 2.13.8.4 PAHP Contract: 2.9.2.1.2.2; 2.9.2.1.2.3 PIHP Contract: 5.10.3	**HSAG Required Evidence:** • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow for updating paper provider directories • Three consecutive provider directory update examples, including the dates for when the updates were made **Evidence as Submitted by the MCE:** • S3_14.1_Narrative, entire document • S3_14.2_Online Provider Directory, entire document • S3_14.3_Provider Load & Update Workflow, entire document • S 3_14.4_Narrative, entire document	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• S3_14.4_Example 1, entire document • S3_14.4_Example 2, entire document • S3_14.4_Example 3, entire document	
MCE Description of Process: Humana maintains an organized process to ensure provider directory information remains accurate and up to date. As outlined in the provider load and update workflow, updates to provider data are systematically evaluated, validated, and incorporated into source systems before being formatted for both online and print directories. The print provider directories are generated from these updated data sources, ensuring members receive the most current provider information. The workflow includes a clear step for producing and mailing updated print directories, demonstrating Humana's commitment to meeting required update frequencies and supporting member access to reliable provider information.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. Information included in the MCE's electronic provider directory is updated no later than 30 calendar days after the MCE receives updated provider information. MCO: a. The web-based online version shall be updated in real time, but no less than weekly. PAHP: a. In accordance with 42 CFR §438.10(h), the PAHP must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly, web-based machine searchable, web-based machine readable, and mobile-enabled. It must be accurate, complete and updated no less than once weekly. 42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating the electronic provider directory • Three consecutive provider directory update examples, including evidence to demonstrate the date the MCE was made aware of the updated provider information and the date the change was reflected in the electronic provider directory • Tracking mechanisms to demonstrate timeliness **Evidence as Submitted by the MCE:** • S3_15.1_Narrative, entire document • S3_15.1_Louisiana Online Provider Finder Tool, entire document	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.13.8.4 PAHP Contract: 2.9.2.1.2.1; 2.9.2.1.2.1 PIHP Contract: 5.10.3	• S3_15.2_Provider Load & Update Workflow, entire document • S3_15.3_Narrative, entire document • S3_15.3_Example 1, entire document • S3_15.3_Example 2, entire document • S3_15.3_Example 3, entire document • S3_15.4_Narrative-Timeliness Tracker, entire document	
MCE Description of Process: Humana ensures that its electronic provider directory is updated promptly whenever new provider information is received. The organization's policy requires that all updates are reflected in the online directory in real time, but at minimum, updates occur weekly. Humana utilizes the PowerBI Platform to continuously track and document the timeliness of these updates, ensuring compliance with regulatory expectations. This process guarantees that the most current provider information is consistently available to members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
16. The MCE's provider directory is made available on the MCE's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) 42 CFR §457.1207 MCO Contract: 2.13.8.1.2 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.10.1	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable provider directory (e.g., .JSON format) • Link to the publicly available machine-readable provider directory on the MCE's website **Evidence as Submitted by the MCE:** • S3_16.1_Narrative, entire document • S3_16.1_Louisiana Online Provider Finder Tool, entire document • S3_16.2_Narrative, entire document • S3_16.3_Narrative, entire document	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • 3_16_Screenshots	
MCE Description of Process: Humana ensures its provider directory is accessible on its website in a machine-readable file and format as specified by federal requirements. The directory data is available through an API endpoint, allowing users and systems to retrieve up-to-date information in formats such as JSON. Humana's policy and procedure documents have been updated to explicitly reference this standard, confirming ongoing compliance. The provider directory is also publicly available through a clearly identified link on the website and is updated daily to maintain current information for members and prospective members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Formulary		
17. The MCE makes available in electronic or paper form the following information about its formulary: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. 42 CFR §438.10(i)(1-2) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: NA.	**HSAG Required Evidence:** • Policies and procedures • Copy of formulary in Word or PDF format (excerpts are acceptable) • Link to the publicly available formulary on the MCE's website **Evidence as Submitted by the MCE:** • S3_17.1_Louisiana Online Provider Finder Tool, pages 4-5 • S3_17.1_Unsecured Provider and Enrollee Website, page 3 • S3_17.2_LDH Preferred Drug List, entire document • S3_17.3_Narrative, entire document	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: Humana ensures members have access to comprehensive formulary information by making details about covered medications, including both generic and brand-name options, readily available. The formulary, which identifies which medications are		

<table>
<tr><th colspan="3">Standard III—Member Information</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">covered and specifies their tier placement, is accessible through a direct link to the Louisiana Department of Health’s Preferred Drug List (PDL) on Humana’s website. Members can view this information electronically at any time, and paper copies can be requested if preferred.</td></tr>
<tr><td colspan="3">HSAG Findings: The State contracted with a single Pharmacy Benefits Manager (PBM) for the Louisiana Medicaid managed care program; therefore, HSAG has determined that this requirement is not applicable. However, the MCE did provide a link on its website to a formulary that the single PBM maintained.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td>18. The MCE’s formulary drug list is made available on the MCE’s website in a machine-readable file and format as specified by the Secretary.
42 CFR §438.10(i)(3)
42 CFR §457.1207
MCO Contract: 2.19.14.3
PAHP Contract: NA
PIHP Contract: None</td><td>HSAG Required Evidence:
• Policies and procedures
• Confirmation of machine-readable formulary (e.g., .JSON format)
• Link to the publicly available machine-readable formulary on the MCE’s website
Evidence as Submitted by the MCE:
• S3_18.1_Narrative, entire document
• S3_18.2_Narrative, entire document
• S3_18.3_Narrative, entire document</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures that its formulary drug list is accessible to members and the public by linking directly to the Preferred Drug List (PDL) established and maintained by the Louisiana Department of Health (LDH) on its website. This approach follows state requirements, which specify the use of the static LDH-provided link to present the formulary in a machine-readable format, as outlined by federal guidance. The PDL includes comprehensive, up-to-date information on covered medications in a format that can be readily used for electronic processing or review.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
</table>

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Electronic Materials and Communications		
19. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCE meets all of the following: a. The format is readily accessible. b. The information is placed in a location on the MCE's website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days. 42 CFR §438.10(c)(6) 42 CFR §457.1207 MCO Contract: 2.14.1.8 PAHP Contract: 2.9.2.1.1; 2.9.2.1.2.5 PIHP Contract: 5.1.14; 5.7	**HSAG Required Evidence:** • Policies and Procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to the MCE's homepage of its website • Tracking mechanisms related to requests for information in paper form that includes the date of the member's request and the date it was provided to the member (e.g., mailed) • Evidence for how members are informed that paper copies of information are available upon request and without charge **Evidence as Submitted by the MCE:** • S3_19.1_Unsecure Provider Member Website P&P, page 4 • S3_19.1_Narrative, entire document • S3_19.2_Narrative, entire document • S3_19.2_Workflow for Member Materials, entire document • S3_19.3_Narrative, entire document • S3_19.4_Link to MCEs Homepage, entire document • S3_19.5_Narrative, entire document	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• S3_19.5_Handbook & Directory Usage Report, entire document • S3_19.6_Narrative, entire document • S3_19.6_2024 Quick Start Guide, page 5 **Additional Documentation:** • 3_19_Letter • 3_19_Narrative	
MCE Description of Process: Humana ensures that all required member information is provided electronically in a manner that is readily accessible and easy to use. Information is prominently displayed on the Humana website, allowing members to easily locate, view, retain, and print relevant materials. All content presented electronically aligns with the format, readability, and language requirements. Members are clearly notified that they may request any information in paper form at no cost, and Humana fulfills such requests within five business days.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's website did not include language informing the member that information that is available in electronic form is available in paper form without charge upon request and provides it upon request within five business days.		
Required Actions: The MCE must inform members on the website that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days.		

Results for Standard III—Member Information							
Total	Met	=	13	X	1	=	13
	Not Met	=	5	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	18	**Total Score**		=	13

Total Score ÷ Total Applicable	=	**72%**

Member Handbook Checklist

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7; 2.13.6.2.26; 2.13.6.2.26 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	1. Benefits provided by the MCE. **Evidence as submitted by the MCE:** • C3a_Member Handbook; pages 39-43	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8; 2.13.6.2.14 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11; 5.9.2.13	2. How and where to access any benefits provided by the State. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 25	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.24 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.27	3. How transportation is provided. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 22	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.16 PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	4. In the case of a counseling or referral service that the MCE does not cover because of moral or religious objections, the MCE informs members that the service is not covered by the MCE. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 44	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207 MCO Contract: 2.4.6.1.4 PAHP Contract: 2.9.7.2 PIHP Contract: 20.39.2.4	5. The MCE informs members how they can obtain information from the State about how to access the services not provided by the MCE because of moral or religious objections. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 44	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. *For the MCOs, this also includes specialized behavioral health benefits and information about health education and promotion programs, including Care Management, tobacco cessation, and problem gaming.* **Evidence as submitted by the MCE:** • C3a_Member Handbook; pages 41-43	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. *The PIHP must also include procedures for plan of care development.* **Evidence as submitted by the MCE:** • C3a_Member Handbook; pages 11, 25 & 35	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14	8. The extent to which, and how, after-hours care is provided. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 17	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.1	9. What constitutes an emergency medical condition and emergency services. **Evidence as submitted by the MCE:** • C3a_Member Handbook; pages 17-18	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.2	10. The fact that prior authorization is not required for emergency services. **Evidence as submitted by the MCE:** • C3a_Member Handbook; pages 25-26	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.5	11. The fact that the member has a right to use any hospital or other setting for emergency care. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 19	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.5	12. Any restrictions on the member's freedom of choice among network providers. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 22	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(vii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.10 PAHP Contract: 2.9.7.2 PIHP Contract: None	13. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCE cannot require members to obtain a referral before choosing a family planning provider. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 51	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207 MCO Contract: 6.36.1 PAHP Contract: 6.17.1 PIHP Contract: NA	14. Cost sharing (if any imposed under the State plan). **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 24	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207 MCO Contract: 2.13.6.2.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.6	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100. **Evidence as submitted by the MCE:** • C3a_Member Handbook, pages 11-12 & 67	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207 MCO Contract: 2.13.6.2.2; 2.13.6.2.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.4	16. The process of selecting and changing the member's primary care provider/primacy dental provider. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 14	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.1	17. The right to file grievances and appeals. **Evidence as submitted by the MCE:** • C3a_Member Handbook; pages 30-31	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.3 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.2	18. The requirements and timeframes for filing a grievance or appeal. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 30	Y ☐ N ☒ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.3	19. The availability of assistance in the filing process for grievances and appeals. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 30	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.6.1	20. The right to request a state fair hearing (SFH) (or a State external review for the Children's Health Insurance Program [CHIP]) after the MCE has made a determination on a member's appeal which is adverse to the member. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 33	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(E) MCO Contract: 2.13.6.2.18.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.5.1; 5.9.2.18.5.2	21. The fact that, when requested by the member, benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the timeframes specified for filing, and that the member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 33	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3) MCO Contract: 2.13.6.2.19; 2.13.6.2.19.1-2.13.6.2.19.4 PAHP Contract: NA PIHP Contract: 5.9.2.19	22. How to exercise an advance directive, as set forth in 42 CFR §438.3(j) *The MCOs must provide a description of advance directives which includes:* *The MCO's policies related to advance directives;* *The enrollee's rights under State Law, including the to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
	Information on how enrollees can file complaints about the failure to comply with an advance directive with the LDH Health Standards Section, Louisiana's Survey and Certification agency; and *Information about where an enrollee can seek assistance in executing an advance directive and to who copies should be given.* **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 27	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.31 PAHP Contract: 2.9.7.2 PIHP Contract: 5.6.1.5; 5.9.2.29	23. How to access auxiliary aids and services, including additional information in alternative formats or languages. *For the MCO, this instruction shall be included in all versions of the Member Handbook in English and Spanish.* *For the PIHP, this instruction shall be included in all versions of the handbook in English, Spanish, and Vietnamese.* **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 67	Y ☐ N ☒ NA ☐
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.22; 2.13.6.2.23 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.21	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 8	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.33 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.9	25. Information on how to report suspected fraud or abuse. **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 35	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.9 PAHP Contract: NA PIHP Contract: NA	26. *The MCOs must include a description on the purpose of the Medicaid ID Card and the MCO Member ID Card and why both are necessary and how to use them.* **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 8	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.20 PAHP Contract: NA PIHP Contract: NA	27. *The MCOs must include information on how to call the Medicaid Customer Service Unit toll-free hotline, visit the Louisiana Medicaid Program website, or visit a regional Louisiana Medicaid Program eligibility office to report any changes to demographic or other information which may affect eligibility;* **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 63	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.21 PAHP Contract: NA PIHP Contract: NA	28. *The MCOs must include information on how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";* **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 16	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.28 PAHP Contract: NA PIHP Contract: NA	29. *The MCOs must include information about the requirement that an Enrollee shall notify the Contractor immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice lawsuit, or has been involved in an automobile accident;* **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 58	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	30. *The MCOs must include reporting requirements for the Enrollee that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the Contractor;*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
MCO Contract: 2.13.6.2.29 PAHP Contract: NA PIHP Contract: NA	**Evidence as submitted by the MCE:** • C3a_Member Handbook; page 63	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.30 PAHP Contract: NA PIHP Contract: NA	31. *The MCOs must include enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor or LDH. This shall include a statement that the Enrollee is responsible for protecting their MCO Member ID Card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the Enrollee's Louisiana Medicaid Program eligibility and/or legal action;* **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 13	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.35 PAHP Contract: NA PIHP Contract: NA	32. *The MCOs must include the date of the last revision;* **Evidence as submitted by the MCE:** • C3a_Member Handbook; page 2	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.37 PAHP Contract: NA PIHP Contract: NA	33. *The MCOs must include Information regarding specialized behavioral health services (SBHS), including, but not limited to:* a. *A description of covered behavioral health services;* b. *Where and how to access behavioral health services and behavioral health providers;* c. *General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices;* d. *Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and*	Y ☐ N ☒ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
	e. *Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.* **Evidence as submitted by the MCE:** • C3a_Member Handbook; pages 40-43	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.3	34. *The PIHP must include CSoC eligibility requirements;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	35. *The PIHP must include Member's Bill of Rights;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.12	36. *The PIHP must include where to find medical necessity criteria on the Contractor's website and how to request hardcopies of medical necessity criteria;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.20	37. *The PIHP must include how to make, change, and cancel appointments and the importance of canceling and/or rescheduling rather than being a "no-show;"* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.22	38. *The PIHP must include family's/caregiver's or legal guardian's role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.23	39. *The PIHP must include generic information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult's engagement, resilience, strength-based and evidence-based practice, and best/proven practices;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.24	40. *The PIHP must include information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.25	41. *The PIHP must include any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.26	42. *The PIHP must include how to identify and contact the WAAs and FSO;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.30	43. *The PIHP must include names, locations, telephone numbers of, and non-English languages spoken by current network providers including identification of providers that are not accepting new patients. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained and details on using the web-based provider directory;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.33	44. *The PIHP must include the date of the last revision;* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	45. *The PIHP must include the mechanism by which a member may submit, whether oral or in writing, a service authorization request for the provision of services; and* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.35	46. *The PIHP must include additional information that is available upon request, including the following:* a. *Information on the structure and operation of the Contractor;* b. *Pharmacy location or medication information availability;* c. *Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and* d. *Service utilization policies* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒

Provider Directory Checklist

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
The MCE makes available in paper form upon request and searchable electronic form, the following information about its network providers:		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	1. The provider's name as well as any group affiliation. **Evidence as submitted by the MCE:** • C2b_1_Directory Screenshot; entire document	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	2. Street address(es). **Evidence as submitted by the MCE:** • C2b_2_Directory Screenshot; entire document	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	3. Telephone number(s). **Evidence as submitted by the MCE:** • C2b_3_Directory Screenshot; entire document	Y ☒ N ☐ NA ☐

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	4. Website Uniform Resource Locater (URL), as appropriate. **Evidence as submitted by the MCE:** • C2b_4_Directory Screenshot; entire document	Y ☐ N ☒ NA ☐
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	5. Specialty, as appropriate. **Evidence as submitted by the MCE:** • C2b_5_Directory Screenshot; entire document	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	6. Whether the provider will accept new members. **Evidence as submitted by the MCE:** • C2b_6_Directory Screenshot; entire document	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2	7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office. **Evidence as submitted by the MCE:** • C2b_7_Directory Screenshot; entire document	Y ☒ N ☐ NA ☐

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1		
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.3	8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment. **Evidence as submitted by the MCE:** • C2b_8_Directory Screenshot; entire document	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(2) 42 CFR §457.1207 MCO Contract: 2.13.8.7.1 PAHP Contract: 2.6.2.7; 2.6.2.10 PIHP Contract: None	9. The MCE provider directory components are included for the following provider types: a. Physicians, including specialists; b. Hospitals; c. Pharmacies; d. Behavioral health providers; The MCO provider directory components are included for the following provider types *and shall be delineated by parish and zip code*: a. *Hospital primary care physician (PCP) groups* b. *Clinic settings* c. *Home and community-based services* d. *Outpatient therapy* e. *Residential substance use* f. *Youth residential services* g. *Inpatient mental health and residential substance use services* h. *Federally qualified health centers (FQHCs)* i. *Rural health clinics (RHCs)* j. *Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.*	Y ☒ N ☐ NA ☐

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
	k. *Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.* l. *Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.* The PAHP provider directory components are included for the following provider types: a. *Endodontists* b. *Maxillofacial surgeons* c. *Oral surgeons* d. *Orthodontists* e. *Pedodontists* f. *Periodontists* g. *Prosthodontists* h. *Special needs pedodontists*	
	Evidence as submitted by the MCE: • C2b_9_Provider Directory; 25, 27, 31, 62, 111, 116, 163, 180, 256, 310, 316, 332, 374 & 439	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: NA	10. *The PAHP provider directory must include the following:* a. *The provider's cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training;* b. *Office hours;* c. *Specific performance indicators;* d. *A statement that some providers may choose not to perform certain services based on religious or moral beliefs;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Not applicable.	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	11. *The PAHP Provider Directory must also include the following:* a. *Providers arranged by name in alphabetical order* b. *Showing the provider's specialty,* c. *Providers listed by specialty in alphabetical order by name.*	Y ☐ N ☐ NA ☒

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • Not applicable.	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.10.4.2; 5.10.4.4; 5.10.4.5; 5.10.4.6	12. *The PIHP Provider Directory must include the following:* a. *Indication of populations served by the provider (e.g., age range of clients) and specialties;* b. *Identification of any restrictions on the member's freedom of choice among providers;* c. *Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours);* d. *Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Not applicable.	

Standard IV—Emergency and Poststabilization Services

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
1. The MCE defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. 42 CFR §438.114(a) 42 CFR §457.1228 MCO Contract: Part 1:, Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S4_1_UMPD; page 16 • S4_1_Physician Agreement; page 16 • S4_1_Ancillary Agreement; page 16 • S4_1_Hospital Agreement; page 16 • S4_1_Member Handbook; pages 12-13	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana Healthy Horizons in Louisiana (Humana) defines an "emergency medical condition" as one presenting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health (or the health of a pregnant woman or her unborn child) in serious jeopardy, causing serious impairment to bodily functions, or resulting in serious dysfunction of any bodily organ or part.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
2. The MCE defines “emergency services” as covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under Title 42. b. Needed to evaluate or stabilize an emergency medical condition. 42 CFR §438.114(a) 42 CFR §457.1228 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S4_2_Ancillary Agreement; page 17 • S4_2_Hospital Agreement; page 16 • S4_2_Physician Agreement; page 16 • S4_2_UMPD; page 16 • S4_1_Member Handbook; pages 14, 20, 31	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana complies with the federal definition of “emergency services” by ensuring coverage for both inpatient and outpatient care provided by qualified healthcare providers, including services necessary to evaluate or stabilize an emergency medical condition.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE defines “poststabilization care services” as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition. 42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 2.4.2.2 PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S4_2_UMPD; page 11 • S4_1_Member Handbook; pages 14, 20 • S4_3_Provider Manual; pages 27, 49 • S4_3_LA Narrative_Provider Manual; entire document	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures compliance with the federal definition of "poststabilization care services" by covering medically necessary services provided after a member has been stabilized following an emergency medical condition, and are intended to maintain, improve, or resolve the member's condition, under the circumstances described in 42 CFR §438.114(e).		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Coverage and Payment		
4. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. 42 CFR §438.114(c)(1)(i) 42 CFR §457.1228 MCO Contract: 2.11.4.1 PAHP Contract: 2.8.3.2 PIHP Contract: 8.3.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services, with the place of service and/or other code(s) that identifies emergency services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_4_LA.CLI.065.065_OON Prior Auth; page 1 • S4_4_LA.CLM.011_LA Claims P&P; pages 6, 12, 23 • S4_4_Claims Response; entire document • S4_1_Member Handbook; pages 14, 20 • S4_3_Provider Manual; page 49	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• S4_3_LA Narrative_Provider Manual; entire document • S4_4_Claim_820241360208739_Example; entire document • S4_4_Claim_820240300382971_Example; entire document • S4_4_Claim_820241030651939_Example; entire document	
MCE Description of Process: Humana's Claims Administration System (CAS) identifies emergency services using place of service and revenue codes, and processes these claims without requiring prior authorization or referral, regardless of the provider's network status.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE does not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of "emergency medical condition." b. A representative of the MCE instructs the member to seek emergency services. 42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228 MCO Contract: 2.11.8.4 PAHP Contract: 2.4.2.3.3; 2.4.2.3.4 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Process to track when an MCE representative instructs a member to seek emergency services (e.g., member services, care management) • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S4_5_LA.CLM.011_LA Claims P&P; pages 6, 14 • S4_2_UMPD; page 16 • S4_1_Member Handbook; page 14 • S4_3_Provider Manual; pages 27, 30, 49 • S4_3_LA Narrative_Provider Manual; entire document • S4_4_Claims Response; entire document • S4_5_LA.MCC.008_24_BH_Crisis_Calls; pages 2-3 • S4_5_Claim_820240600103855_Example; entire document • S4_5_Claim_820241840218456_Example; entire document • S4_5_Claim_820243170829725_Example; entire document	
MCE Description of Process: Humana's Claims Administration System (CAS) identifies emergency services using place of service and revenue codes, and processes these claims without requiring prior authorization or referral, regardless of the provider's network status. Humana pays for emergency services, even if it is later determined that the absence of immediate medical attention would not have resulted in serious outcomes, and when a Humana representative instructs the member to seek emergency care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Additional Rules for Emergency Services		
6. The MCE does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCE, or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. 42 CFR §438.114(d)(1) 42 CFR §457.1228 MCO Contract: 2.11.8.3; 2.11.8.5 PAHP Contract: 2.8.3.3 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_6_LA.CLM.011_LA Claims P&P; page 16 • S4_2_UMPD; pages 6, 7, 13, 14 • S4_6_Member Handbook; page 20 • S4_3_Provider Manual; page 49 • S4_3_LA Narrative_Provider Manual; entire document • S4_4_Claims Response; entire document • S4_6_Claim_820240740137884_Example; entire document • S4_6_Claim_820241540068395_Example; entire document • S4_6_Claim_820242752095606_Example; entire document	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana's Claims Administration System (CAS) identifies emergency services using place of service and revenue codes, and processes these claims without requiring prior authorization or referral, regardless of the provider's network status. Humana does not restrict what qualifies as an emergency based on lists of diagnoses or symptoms and does require notification of the member's screening and treatment to be received within 10 calendar days.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) 42 CFR §457.1228 MCO Contract: 6.36.2 PAHP Contract: 2.8.3 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency and poststabilization services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_7_LA.MAR.083_Member Cost Sharing; page 1 • S4_7_LA.CLM.011_LA Claims P&P; pages 6, 7, 14 • S4_4_Claims Response; entire document • S4_7_Member Handbook; page 14 • S4_7_Provider Manual; page 89 • S4_7_LA Narrative_Provider Manual; entire document	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• S4_7_Claim_820242200271381_Example; entire document • S4_7_Claim_820242800003467_Example; entire document • S4_7_Claim_820243591811175_Example; entire document	
MCE Description of Process: Humana ensures compliance with 42 CFR §438.114(d)(2) and 42 CFR §457.1228 by processing emergency services claims, including services necessary to evaluate or stabilize an emergency medical condition, without requiring prior authorization or referral, and regardless of whether the provider is in-network or out-of-network.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCE. 42 CFR §438.114(d)(3) 42 CFR §457.1228 MCO Contract: 2.11.8.8 PAHP Contract: 2.4.2.3.5 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Three case examples of a peer-to-peer discussion between the MCE and emergency provider pertaining to emergency services **Evidence as Submitted by the MCE:** • S4_2_UMPD; page 5 • S4_3_Provider Manual; page 8, 46 • S4_3_LA Narrative_Provider Manual; entire document • S4_8_Emergency Services; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana complies with 42 CFR §438.114(d)(3) and 42 CFR §457.1228 by not requiring prior authorization for emergency and poststabilization services, thereby ensures that emergency care decisions remain under the authority of the treating provider. The determination of when a member is sufficiently stabilized for transfer or discharge is made solely by the attending emergency physician or provider, and this decision is binding on Humana.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Coverage and Payment of Poststabilization Care Services		
9. The MCE is financially responsible for post-stabilization care services obtained within or outside the MCE that are pre-approved by a plan provider or other MCE representative. 42 CFR §422.113(c)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7 PAHP Contract: 2.4.2.2 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for post stabilization services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_9_LA.CLM.011_LA Claims P&P; page 14 • S4_2_UMPD; pages 10, 11 • S4_3_Provider Manual; pages 27, 49 • S4_3_LA Narrative_Provider Manual; entire document • S4_9_Claims Response; entire document • S4_9_Claim_820240320551994_Example; entire document • S4_9_Claim_820241201261024_Example; entire document • S4_9_Claim_820242621929623_Example; entire document	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard IV—Emergency and Poststabilization Services</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCE Description of Process: Humana does not distinguish between emergency and post-stabilization services in its claims processing. Humana’s Claims Administration System (CAS) identifies services rendered in the emergency department using appropriate place of service and revenue codes, and processes these claims without requiring prior authorization or referral, regardless of the provider's network status.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">10. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or other MCE representative, but administered to maintain the member’s stabilized condition within one hour of a request to the MCE for pre-approval of further poststabilization care services.
42 CFR §422.113(c)(2)(ii)
42 CFR §438.114(e)
42 CFR §457.1228
MCO Contract: 2.11.8.7.2.1
PAHP Contract: 2.4.2.2.1.2
PIHP Contract: 8.8.1</td><td>HSAG Required Evidence:
• Policies and procedures
• Provider materials, such as the provider manual
• Workflow for claims review process for poststabilization services</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S4_10_LA.CLM.011_LA Claims P&P; page 14
• S4_10_Provider Manual; page 49
• S4_10_LA Narrative_Provider Manual; entire document
• S4_9_Claims Response; entire document</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures compliance with federal and contract requirements regarding financial responsibility for post-stabilization care services. Humana does not distinguish between emergency and post-stabilization services in its claims processing. Humana’s Claims Administration System (CAS) identifies services rendered in the emergency department using appropriate place of service and revenue codes, and processes these claims without requiring prior authorization or referral, regardless of the provider's network status.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
</table>

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
11. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member's stabilized condition if: a. The MCE does not respond to a request for pre-approval within one hour. b. The MCE cannot be contacted. c. The MCE representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCE must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met. 42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7.2.2 PAHP Contract: 2.4.2.2.1.1; 2.4.2.2.1.2; 2.4.2.2.1.3 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services • Process to track requests for pre-approval of poststabilization care services and timeliness of the MCE's response • One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services **Evidence as Submitted by the MCE:** • S4_11_LA.CLM.011_LA Claims P&P; page 14 • S4_11_Provider Manual; page 49 • S4_11_LA Narrative_Provider Manual; entire document • S4_9_Claims Response; entire document • S4_11_P2P Post-Stabilization Case; entire document • S4_11_Emergency Poststabilization Services; entire document • S4_11_Timeliness MockUp; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures compliance with federal and contract requirements regarding financial responsibility for post-stabilization care services. Humana does not distinguish between emergency and post-stabilization services in its claims processing. Humana's Claims Administration System (CAS) identifies services rendered in the emergency department using appropriate place of service and revenue codes, and processes these claims without requiring prior authorization or referral, regardless of the provider's network status.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. The MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission. 42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: None PAHP Contract: None PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow for claims review process for poststabilization services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • S4_12_LA.CLM.011_LA Claims P&P; page 14 • S4_3_Provider Manual; page 59, 60 • S4_3_LA Narrative_Provider Manual; entire document • S4_12_Member Handbook; page 20 • S4_9_Claims Response; entire document • S4_12_Claim_820240170709426_Example; entire document • S4_12_Claim_820243441222445_Example; entire document • S4_12_Claim_820241300577670_Example; entire document	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures compliance with federal and contract requirements regarding financial responsibility for post-stabilization care services. Humana limits member charges for poststabilization care to amounts no greater than what would have been charged if the services were obtained directly through Humana.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
End of the MCE's Financial Responsibility		
13. The MCE's financial responsibility for poststabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care. b. A plan physician assumes responsibility for the member's care through transfer. c. An MCE representative and the treating physician reach an agreement concerning the member's care. d. The member is discharged. 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.8 PAHP Contract: None PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S4_13_LA.CLM.011_LA_Claims P&P; page 14 **Additional Documentation:** • 4_13_UMPD - DRAFT	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures compliance with federal and contract requirements regarding financial responsibility for post-stabilization care services. Humana does not distinguish between emergency and post-stabilization services in its claims processing. Humana's Claims Administration System (CAS) identifies services rendered in the emergency department using appropriate place of service and revenue codes, and processes these claims without requiring prior authorization or referral, regardless of the provider's network status.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Results for Standard IV—Emergency and Poststabilization Services							
Total	Met	=	13	X	1	=	13
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	13	**Total Score**		=	13

Total Score ÷ Total Applicable	=	**100%**

Standard V—Adequate Capacity and Availability of Services

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
1. The MCE maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) 42 CFR §457.1230(a) MCO Contract: 2.9.2.1 PAHP Contract: 2.6.4.1.1; 2.6.4.1.2; 2.6.6.9 PIHP Contract: 6.1.1	**HSAG Required Evidence:** • Policies and procedures • Analysis of provider network linguistic capabilities • Analysis of provider network capabilities to serve members with special health care needs • Provider materials, such as the provider manual • One example of each type of provider contract (ancillary, hospital, and individual/group) **Evidence as Submitted by the MCE:** • S5_1.1_Prov Net Dev Mgmt Plan; page 3 • S5_1.1_ADA Violation; page 1 • S5_1.2_Linuistic Capabilities; entire document • S5_1.3_SCHN Providers; entire document • S5_1.4_Provider Manual; page 75 • S5_1.4_Provider Manual Narrative; entire document • S5_1.5_Physician Agreement; entire document • S5_1.5_Hospital Agreement; entire document • S5_1.5_Ancillary Agreement; entire document	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • 5_1_Narrative • 5_1_Screenshot5_1_LA Medicaid BH Tables_Q4 20245_1_LA Medicaid BH Provider Maps_Q4 20245_1_Special Services Def per Contract Lang • 5_1_Special Services GeoMapping Ex	
MCE Description of Process: Humana ensures that its provider network is comprehensive and accessible by maintaining written agreements with participating providers, which are regularly monitored to guarantee compliance with adequacy standards. The network is structured to provide all covered services to every member, including individuals with limited English proficiency or physical and mental disabilities. Providers are required to offer reasonable accommodation and physical access, and to deliver services without discrimination, thus supporting equitable access to care for all members.		
HSAG Findings: HSAG has determined that the MCO has not met the requirements for this element. HUM's provider agreements demonstrated its written agreements with providers. HUM's Provider Network Development and Management Plan and ADA Violation policies outlined HUM's commitment to monitoring its network adequacy. HUM's Linguistic Capabilities and SCHN Providers spreadsheets provided the languages spoken by HUM's network providers in tabular form and a list of behavior health providers by specialty type (attention-deficit disorder [ADD], attention-deficit hyperactivity disorder [ADHD], etc.), respectively. However, HUM's spreadsheets did not analyze the provider network's capabilities to serve members with limited English proficiency nor special health care needs, such as physical or mental disabilities. HUM subsequently submitted a Power BI (PBI) cloud-based report with Narrative (Report), which was outside the audit time frame, for all specialty types across physical and behavioral health providers as well as screenshots of the time/distance standards and its geo access tables for providers treating various ASAM levels of care. HUM's subsequent submissions did not identify how HUM analyzed its provider network's capabilities to serve members with limited English proficiency nor special health care needs, such as physical or mental disabilities.		
Required Actions: The MCE must monitor its provider network to ensure adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.		
2. The MCE provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Coverage/authorization guidelines	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
member's designated source of primary care if that source is not a women's health specialist. 42 CFR §438.206(b)(2) 42 CFR §457.1230(a) MCO Contract: 2.9.17 PAHP Contract: NA PIHP Contract: NA	**Evidence as Submitted by the MCE:** • S5_2.1_Narrative; entire document • S5_2.2_Member Handbook; page 41 • S5_2.3_Provider Manual; pages 11-12 • S5_1.4_Provider Manual Narrative; entire document **Additional Documentation:** • 5_2_Adequacy Gap Process • 5_2_LA 220 Mapping Analysis • 5_2_Female BH GeoMapping Ex • 5_2_Female PH GeoMapping Ex • 5_2_Female Speciality Serv per Contracting • 5_2_LA BH Tables Q4 2024	
MCE Description of Process: Humana ensures that female members have direct access to in-network women's health specialists for routine and preventive care, such as annual gynecological exams, without needing a referral from their primary care provider. This access is provided in addition to the members' primary care services, ensuring comprehensive women's health support. Female members are informed of this benefit and can choose their preferred women's health specialist within the network to meet their unique healthcare needs.		
HSAG Findings: HSAG has determined that the MCO has not met the requirements for this element. HUM's Provider Manual stated its covered benefits related to women's routine and preventive health services for females ages 21 years and older without the need for prior authorization. HUM's Member Handbook stated its covered benefits related to family planning services but not women's routine and preventive health services. HUM subsequently submitted screenshots of the time/distance access standards and its geo access tables for behavioral health providers specializing in pregnancy-related and postpartum mental health disorders and OB/GYNs, which did not meet the requirements of this element.		
Required Actions: The MCE must demonstrate, through policy, that it provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
3. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §438.206(b)(7) 42 CFR §457.1230(a) MCO Contract: 2.9.17.1 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • List of provider types designated as family planning providers • Network adequacy analysis of family planning providers **Evidence as Submitted by the MCE:** • S5_5_3.1_Prov Net Dev Mgmt Plan; pages 4-5 • S5_3.2_Member Handbook; pages 46-47 • S5_3.3_Family Planning Narrative; entire document • S5_3.4_Network Adq Family Planning; entire document • S5_3.4_NA Fam Planning Narrative; entire document **Additional Documentation:** • 5_2_Adequacy Gap Process • 5_2_LA 220 Mapping Analysis • 5_2_Female BH GeoMapping Ex • 5_2_Female PH GeoMapping Ex • 5_2_Female Speciality Serv per Contracting • 5_2_LA BH Tables Q4 2024	☐ Met ☒ Not Met ☐ NA

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<tr><th colspan="3">Standard V—Adequate Capacity and Availability of Services</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures members have timely access to family planning services by maintaining a robust network that includes Family Planning Clinics, primary care providers, obstetricians and gynecologists, and other qualified practitioners such as certified nurse midwives and nurse practitioners. The organization regularly monitors the availability of these providers using network adequacy analysis and geo-access reporting to confirm that members can reach family planning services without unnecessary delays. By designating a broad range of provider types for family planning, Humana supports member choice and accessibility, ensuring that covered services are available throughout its service area.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCO has not met the requirements for this element. HUM's Provider Network and Development Management Plan policy stated that HUM monitors "the sufficiency of the provider network, members ability to access care, including monitoring of appointment time availability, and ensuring access to a choice of providers." HUM's Network Adequacy Family Planning spreadsheet and Narrative demonstrated that HUM did not meet the time/distance access standard for OB/GYNs for women 5 percent of the time. HUM subsequently submitted screenshots of the time/distance access standards and its geo access tables for behavioral health providers specializing in pregnancy-related and postpartum mental health disorders and OB/GYNs, which did not meet the requirements of this element.</td></tr>
<tr><td colspan="3">Required Actions: The MCE must demonstrate, through monitoring and data analysis, that its network includes sufficient family planning providers to ensure timely access to covered services.</td></tr>
<tr><td>4. The MCE provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.
42 CFR §438.206(b)(3)
42 CFR §457.1230(a)
MCO Contract: 2.13.6.2.32
PAHP Contract: 2.5.2.1.1.3; 2.6.6.2.5
PIHP Contract:7.2.8</td><td>HSAG Required Evidence:
• Policies and procedures
• Member materials, such as the member handbook
• Second opinion tracking/analysis
• Coverage/authorization guidelines
Evidence as Submitted by the MCE:
• S5_4.1_UMPD; page 16
• S5_4.2_Member Handbook; page 16
• S5_4.3_LOA Log; entire document
• S5_4.3_LOA Log Narrative; entire document
• S5_4.4_OON-OOS Prior Auth; page 1 & 2</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
</table>

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • 5_4_UMPD 2025 DRAFT • 5_4_Second Opinion Narrative	
MCE Description of Process: Humana ensures that members seeking a second medical opinion have access to qualified providers within its network. If an appropriate in-network provider is not available, Humana arranges for the member to obtain a second opinion from an out-of-network provider without any cost to the member. The process includes verifying provider availability and, when necessary, coordinating authorization and care logistics to facilitate timely access.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCE adequately and timely covers these services out of network for the member, for as long as the MCE provider network is unable to provide them. 42 CFR §438.206(b)(4) 42 CFR §457.1230(a) MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Network adequacy monitoring mechanisms • Three examples of executed single case agreements **Evidence as Submitted by the MCE:** • S5_4.4_OON-OOS Prior Auth; page 2 • S5_5.2_Member Handbook; pages 6 & 15 • S5_5.3_Net Adeq Analystics; page 1 • S5_5.4_LOA Example 1; entire document • S5_5.4_LOA Example 2; entire document • S5_5.4_LOA Example 3; entire document **Additional Documentation:** • S5_4.3_LOA Log; entire document	☒ Met ☐ Not Met ☐ NA

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<tr><th colspan="3">Standard V—Adequate Capacity and Availability of Services</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td></td><td>• 5_5_Internal PBI NA Reporting
• 5_5_Internal PBI NA Reporting 2
• 5_5_Internal Quest NA Reporting</td><td></td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures that when a needed service cannot be provided within its network, members receive timely access to the required care from out-of-network providers. The plan follows a clear process to identify network gaps, and, when necessary, arranges for covered services to be delivered by qualified out-of-network providers. Prior authorization requirements are used to confirm the need for out-of-network care, and members are not subject to additional costs for these approved services.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">6. The MCE requires out-of-network providers to coordinate with the MCE for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.
42 CFR §438.206(b)(5)
42 CFR §457.1230(a)
MCO Contract: 2.9.2.3
PAHP Contract: 2.6.1.8
PIHP Contract: 6.2.3.1.7</td><td>HSAG Required Evidence:
• Policies and procedures
• Claims processing guidelines
• Member materials, such as the member handbook
• Provider materials, such as materials on the MCE’s website
• Three examples of executed single case agreements</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S5_6.1_Member LOA Template; entire document
• S5_6.1_LOA; entire document
• S5_6.1_Narrative; entire document
• S5_6.2_Claims PP; page 6
• S5_6.3_Member Handbook; page 23
• S5_6.4_Screenshots; entire documents</td></tr>
</table>

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• S5_6.4_Provider Manual; page 39 • S5_5.4_LOA Example 1; entire document • S5_5.4_LOA Example 2; entire document • S5_5.4_LOA Example 3; entire document **Additional Documentation:** • 5_6_Letters of Agreement • 5_6_LA Member Specific LOA	
MCE Description of Process: Humana ensures that when members receive covered services from out-of-network providers, those providers must coordinate with Humana for payment processing. The member is protected from higher costs by guaranteeing that their financial responsibility does not exceed what they would pay for the same services within the network. Humana manages claims directly with the out-of-network provider, so members are not billed for additional charges beyond standard in-network rates.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
42 CFR §438.206(b)(6) requires the MCE to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VIII: Provider Selection. [this could change depending on each state's requirements]		
Timely Access		
7. The MCE meets and requires its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist. 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: 2.9.3.1 PAHP Contract: 2.6.5.1; 2.6.5.3 PIHP Contract: 7.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Network analysis (e.g., appointment standards) • HSAG will also use the results of the Access Standards: Appointment Times Checklist	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S5_7.1_Prov Net Dev Mgmt Plan; pages 4-5 • S5_7.1_Provider Manual; pages 9-10 • S5_7.1_Performance Measure; Measure 1 Tab • S5_7.2_Access to Appt Standards; entire document • S5_7.3_Performance Measure; entire document • S5_7.4_Performance Measure; Measure 1 Tab **Additional Documentation:** • 5_7_LA 2024 Provider Satisfaction Final Report • 5_7_Q4 2024 0359 ATC Report • 5_7_Q3 2024 0359 ATC Report • 5_7_Q2 2024 0359 ATC Report • 5_7_Q1 2024 0359 ATC Report • 5_7_Q2 2024 Phone No to Investigate Outreach • 5_7_Q2 2024 BH Mystery Shopping Outreach • 5_7_Q2 2024 BH Emergent Care Outreach • 5_7_Q4 2024 Urgent-Routine Outreach	
MCE Description of Process: Humana ensures that both the organization and its network providers adhere to established state standards for timely access to care, carefully considering the urgency of each member's needs. Appointment availability is monitored regularly to confirm that members can access emergency care within one-hour, urgent care within 24 hours, non-urgent sick visits within 72 hours, and routine care within six weeks. Specialized standards also exist for behavioral health, prenatal, and family planning services to guarantee prompt access. Ongoing oversight, including appointment audits and corrective action plans when standards are not met, supports consistent provider compliance and ensures members receive timely, appropriate care.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO has not met the requirements for this element. HUM's Provider Network Development and Management Plan policy stated that HUM conducts a quarterly "blind survey" to "evaluate appointment availability" of "a listing of PCP, Specialists, and Specialized Behavioral Health provider locations," which includes a minimum of "10% of unique provider locations for each provider type per quarter resulting in at least 40% of all providers surveyed annually." HUM provided no evidence of network analysis for PCPs or specialist provider locations. HUM's Access to Appointment Standards flyer and Provider Manual required providers to comply with the appointment time access standards, which were listed in tabular form. HUM's network analysis regarding compliance with the appointment time access standards met the requirements for this element, but only for behavioral health providers. HUM's subsequent submission did not include a network analysis regarding compliance with the appointment time access standards for PCPs nor specialist provider locations, as required in HUM's Provider Network Development and Management Plan policy. HUM's Appointment Times Checklist and the accompanying evidence were also used by the HSAG reviewer to evaluate this requirement. HUM did not include the requisite data necessary to score HUM's Appointment Times Checklist.		
Required Actions: The MCE must ensure, through monitoring and data analysis, its network providers meet State standards for timely access to care and services, taking into account the urgency of the need for services.		
8. MCO: The MCE ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members. PAHP: Network providers must offer office hours at least equal to those offered by commercial dental insurance plans. 42 CFR §438.206(c)(1)(ii) 42 CFR §457.1230(a) MCO Contract: 2.9.3.2 PAHP Contract: 2.6.2.4 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Audit or secret shopper results/reports **Evidence as Submitted by the MCE:** • S5_8.1_Performance Measure; Measure 1 Tab • S5_8.1_Provider Manual; pages 9-10 • S5_8.1_Prov Net Mgmt Plan; pages 4-5 • S5_8.1_Availability and Access; page 5 • S5_7.2_Access to Appt Standards • S5_8.2_Provider Manual; page 7 • S5_8.2_Physician Agreement; page 8	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• S5_8.3_Performance Measure; Measure Tab 1 • S5_8.3_Availability and Access; page 5 • S5_8.3_Prov Net Mgmt Plan; pages 4-5 **Additional Documentation:** • 5_7_Provider Data Quality Monitoring • 5_7_LA Audit Q1-Q4 20245_8_Narrative • 5_8_Secret Shopper Audit Workflow	
MCE Description of Process: Humana requires its network providers to maintain hours of operation that are at least as extensive as those offered to commercial members, or, for providers serving only Medicaid members, hours that are comparable to those in the Medicaid fee-for-service program. The organization regularly monitors provider practices to ensure compliance with these standards and incorporates oversight into its network adequacy reviews.		
HSAG Findings: HSAG has determined that the MCO has not met the requirements for this element. While HUM presented a robust workflow and process regarding ensuring the accuracy of its Provider Directory, HUM did not provide evidence that it ensures, through monitoring and data analysis, that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members, or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members.		
Required Actions: The MCE must ensure, through monitoring and data analysis, that its network providers' hours of operation are no less than the hours of operation offered to commercial members, or comparable to Medicaid FFS if the provider serves only Medicaid members.		
9. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. 42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a) MCO Contract: 2.9.3.3 PAHP Contract: 2.9.10.2 PIHP Contract: 5.11.6	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Results of provider monitoring mechanisms • Audit or secret shopper results/reports	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S5_9.1_Availability and Access; page 5 • S5_9.1_Performance Measure; Measure Tab 1 • S5_9.1_Provider Manual; pages 9-11 • S5_9.1_Prov Net Dev Mgmt Plan; pages 4-5 • S5_9.2_Access to Care; entire document • S5_9.3_Performance Measure; Measure 1 Tab • S5_9.4_Performance Measure; Measure 1 Tab **Additional Documentation:** • 5_9_Provider Manual • 5_9_Physican Agreement	
MCE Description of Process: Humana ensures that members have continuous access to medically necessary services by making them available 24 hours a day, seven days a week. The process involves coordinating care so that urgent medical needs are addressed promptly at any time, ensuring patient safety and well-being.		
HSAG Findings: HSAG has determined that the MCO has not met the requirements for this element. While HUM's Provider Network Availability and Access and Provider Network Development and Management Plan policies, Provider Manual, Provider Agreement, and Access to Care flyer stated the requirement for this element, including but not limited to after-hours access, HUM did not provide evidence that it ensures, through monitoring and data analysis, that its network providers make the services included in the contract available 24 hours a day, seven days a week, when medically necessary.		
Required Actions: The MCE must ensure, through monitoring and data analysis, that its network providers make the services included in the contract available 24 hours a day, seven days a week, when medically necessary.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
10. The MCE establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. a. The MCE monitors network providers regularly to determine compliance. b. The MCE takes corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a) MCO Contract: 2.9.3.5 PAHP Contract: 2.6.5.2 PIHP Contract: 6.8.6; 7.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Results of provider monitoring mechanisms • Audit or secret shopper results/reports • Three examples of corrective action taken when a provider fails to meet timely access standards **Evidence as Submitted by the MCE:** • S5_10.1_Prov Net Mgmt Plan; pages 4-5 • S5_10.1_Performance Measure; Measure 1 Tab • S5_10.1_Provider Manual; pages 9-11 • S5_10.1_Access to Care; entire document • S5_10.2_Performance Measure; Measure 1 Tab • S5_10.4_Narrative; entire document **Additional Documentation:** • 5_7_Q4 2024 0359 ATC Report • 5_7_Q3 2024 0359 ATC Report • 5_7_Q2 2024 0359 ATC Report • 5_7_Q1 2024 0359 ATC Report • 5_10_LDH Approved - LA SBHS Emergent Phone Survey 6.6.23	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that members have timely access to care and services by implementing regular monitoring of its network providers. Through systematic reviews such as surveys, audits, and appointment availability checks, Humana evaluates provider compliance with established access standards. If deficiencies are identified, Humana initiates corrective actions to address and resolve the issues, which may include the development and monitoring of corrective action plans.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Access and Cultural Considerations		
11. The MCE participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. 42 CFR §438.206(c)(2) 42 CFR §457.1230(a) MCO Contract: 2.4.1.11 PAHP Contract: 2.1.2 PIHP Contract: 5.1.8	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Cultural competency plan • Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory • Analysis of provider network linguistic capabilities • Analysis of provider network cultural competence **Evidence as Submitted by the MCE:** • S5_11.1_Prov Finder Tool; entire document • S5_11.1_Covered Benefits; pages 1 & 4 • S5_11.1_Clinical Narrative; entire document • S5_11.2_Provider Manual; pages 81-82 • S5_11.2_Physician Agreement; page 7 • S5_11.3_CLAS Work Plan; page 7 • S5_11.4_Physician Finder; entire document • S5_11.6_CLAS Evaluation; page 1 **Additional Documentation:** • 5_1_Narrative	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• 5_1_Screenshot • 5_11_LA.ADA.013 Non-Discrimination of HealthCare Services • 5_11_LA CLAS Program Eval5_11_LA Market CLAS Program Eval • 5_11_LDH Health Equity Year-End Report Template 2024	
MCE Description of Process: Humana implements a comprehensive Culturally and Linguistically Appropriate Services (CLAS) program to promote the delivery of services that meet the diverse needs of all members. This includes providing language assistance, interpreter services, and culturally competent care to individuals with limited English proficiency, as well as to those from various cultural, ethnic, and disability backgrounds. Humana regularly assesses its provider network for cultural and linguistic responsiveness and offers ongoing training and resources to both staff and providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Accessibility Considerations		
12. The MCE ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) 42 CFR §457.1230(a) MCO Contract: 2.9.2.2 PAHP Contract: 2.6.9.5.4 PIHP Contract: 5.13.1.1.21; 6.1.14	**HSAG Required Evidence:** • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers' accessibility • Example(s) of provider profiles (i.e., accessibility accommodations (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment)) on provider directory	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• Analysis of provider network capability to provide services to members with physical or mental disabilities • Surveys or site review results	
	Evidence as Submitted by the MCE: • S5_12.1_Cred Application; page 2, 3, 4, 5 & 10 • S5_12.1_ADA Violation; page 1 • S5_12.2_Provider Manual; page 81 • S5_12.2_Provider Agreement; page 7 • S5_12.3_Cred Application; page 2, 3, 4, 5 & 10 • S5_12.4_Provider Profiles Narrative; entire document • S5_12.5_Spec Needs Prov; entire document • S5_12.6_Cred Recred; pages 33-34 **Additional Documentation:** • 5_12_LA Standardized Credentialing Application • 5_12_Narrative – Mechanisms • 5_12_Narrative - Monitor • 5_12_LA Cred + Recred Policy	
MCE Description of Process: Humana ensures that network providers offer physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities by requiring compliance with all applicable federal and state accessibility laws, including the Americans with Disabilities Act (ADA). Providers must attest to the accessibility of their facilities and services during the credentialing process, and this information is reflected in provider profiles and directories. Humana also maintains processes to address grievances regarding accessibility and offers support services such as interpreter assistance and auxiliary aids at no cost to members.		
HSAG Findings: HSAG has determined that the MCO has not met the requirements for this element. HUM's Credentialing and Recredentialing policy, Provider Manual, and Provider Agreement required providers to provide "physical access, reasonable accommodations,		

<table>
<tr><th colspan="3">Standard V—Adequate Capacity and Availability of Services</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">and accessible equipment for Medicaid members with physical or mental disabilities.” HUM’s Standardized Credentialing Application required providers to attest to what, if any, handicapped access exists at the provider location as well as whether the provider location meets the Americans with Disabilities Act (ADA) accessibility requirements. HUM’s Credentialing and Recredentialing policy also stated that the provider being credentialed or recredentialed must “supply evidence of an on-site quality assessment” from an accrediting body, the State, or CMS. HUM also stated that it reserves the right to conduct an on-site if the “CMS or state review is older than three years.” HUM also stated that if the “state or CMS has not conducted a site review of the provider and the provider is in a rural area (as defined by the U.S. Census), HUM may choose not to conduct a site visit.” HUM’s Narrative stated that “Provider Relations staff perform both routine, scheduled visits, and ad hoc visits to provider offices throughout the year. The frequency of these visits follows departmental guidelines and is based on provider needs and operational considerations to ensure ongoing compliance and promote quality improvement. Specifically, Tier 1 providers are engaged monthly, while Tier 2 providers are visited quarterly. During each site visit, staff evaluate not only the clinical environment but also key accessibility factors, such as signage, parking availability, physical access for individuals with disabilities, wait times, and administrative procedures for scheduling appointments. These assessments reinforce Humana’s commitment to maintaining high standards for provider accessibility and service.” HUM provided no evidence of these “routine, scheduled visits, and ad hoc visits to provider offices throughout the year,” nor did HUM provide an analysis of provider network capability to provide services to members with physical or mental disabilities.</td></tr>
<tr><td colspan="3">Required Actions: The MCE must ensure, through monitoring and data analysis, that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</td></tr>
<tr><th colspan="3">Basic Rule</th></tr>
<tr><td>13. The MCE gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State’s standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).
a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:
i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and</td><td>HSAG Required Evidence:
• Policies and procedures
• Network adequacy reports/analyses
• Exceptions approved by the State
• HSAG will also use the results of the Access Standards: Time/Distance Checklist
• HSAG will also use the results of the Access Standards: Member-to-Provider Ratio Checklist
Evidence as Submitted by the MCE:
• S5_13.1_Network Adequacy; entire document</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
</table>

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
supports (LTSS) that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. PIHP a. The PIHP shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access Standards and services upon execution of the Contract and at any time there has been a change in the PIHP's operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population). 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b) MCO Contract: 2.9.1.2 PAHP Contract: 2.6.4; 2.6.5 PIHP Contract: 6.2.3.1; 6.3.2	• S5_13.2_Provider Maps; entire document • S5_13.2_LA Medicaid Network; entire document • S5_13.3_Exceptions; entire document **Additional Documentation:** • 5_13_Screenshots	
MCE Description of Process: Humana ensures it can serve the expected enrollment in its service area by regularly analyzing its provider network to confirm that an adequate range of preventive, primary care, specialty, and long-term services and supports are available. Humana uses tools such as geographic mapping and network adequacy reports to assess provider numbers, types, and geographic distribution against established state standards. These assessments are conducted at least monthly, and results are submitted to the State in the required format to demonstrate compliance.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's Network Adequacy Analytics policy and Network Adequacy Reports demonstrated HUM's commitment to meet access to care standards. HUM's Time/Distance Checklist and Member-to-Provider Ratio Checklist were used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified. Of note, HUM stated in narrative form that the MCE did not request any exceptions from the State.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must ensure it offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area as well as maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.		
Timing		
14. The MCE submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the MCE's operations that would affect the adequacy of capacity in services, including: i. Changes in MCE services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCE. 42 CFR §438.207(c) 42 CFR §457.1230(b) MCO Contract: 2.9.1.2 PAHP Contract: 2.1.5.2 PIHP Contract: 6.3.2; 6.2.1; 6.2.2	**HSAG Required Evidence:** • Policies and procedures • Assurances of adequate capacity and services submissions to the State (annual and/or as required by the State) • Assurances of adequate capacity and services submission to the State due to a significant change **Evidence as Submitted by the MCE:** • S5_14.1_Prov Net Dev Mgmt Plan; pages 3-5 • S5_14.2_220 Report; entire document • S5_14.2_Provider Maps; entire document • S5_14.2_LA Medicaid Network; entire document • S5_14.2_328 Report Q1; entire document • S5_14.2_328 Report Q2: entire document • S5_14.2_328 Report Q3: entire document • S5_14.3_Provider Attestation; entire document • S5_14.3_Net Adeq Project; entire document • S5_14.3_Net Adeq Project Exit Int; entire document **Additional Documentation:** • 5_14_Screenshots	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana maintains ongoing compliance with state and federal requirements by regularly submitting documentation to demonstrate network adequacy and capacity to serve members. Submissions are made at the initiation of the contract, annually, and whenever there is a significant operational change that may impact service capacity, such as changes in benefits, provider network composition, payment structures, or the enrollment of new populations. These submissions include detailed analyses of provider access, geographic distribution, time and distance standards, and member-to-provider ratios, using up-to-date data validated through internal audits and state-specified formats.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Exceptions Process		
15. To the extent the State permits an exception to any of the provider-specific network standards, MCO: a. *The MCO must submit any requests for exceptions for distance or appointment accessibility standards in writing to LDH for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.* PAHP: a. *Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.* PIHP: a. *Requests for exceptions as a result of prevailing community standards for geographic accessibility standards must be submitted in writing to LDH for approval.*	**HSAG Required Evidence:** • Policies and procedures • Network monitoring report(s) • Exceptions requested by the MCE, if applicable • Exceptions approved by the State, if applicable **Evidence as Submitted by the MCE:** • S5_15.1_Exceptions; entire document • S5_15.2_Network Narrative; entire document • S5_15.2_Provider Maps; entire document • S5_15.2_LA Medicaid Network; entire document • S5_15.3_Exceptions; entire document • S5_15.4_Exceptions; entire document	☐ Met ☐ Not Met ☒ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b) MCO Contract: 2.9.5; 2.9.5.2 PAHP Contract: 2.6.1.8; 2.6.2.6 PIHP Contract: 6.3.1.1.3		
MCE Description of Process: Humana ensures compliance with state requirements for provider-specific network standard exceptions by maintaining a clear internal process. While no exceptions have been requested or granted as of the most recent reporting period, Humana is developing internal policies to address potential future needs for such exceptions. Should an exception become necessary, Humana will prepare and submit a written request to the Louisiana Department of Health (LDH) in the required format, including relevant data on the local provider population. This approach demonstrates Humana's commitment to meeting regulatory standards and maintaining adequate network capacity and accessibility for its members.		
HSAG Findings: The MCE confirmed that it did not submit any requests for exceptions to the State in 2024; therefore, HSAG has determined that this element is not applicable.		
Required Actions: No action required.		

Results for Standard V—Adequate Capacity and Availability of Services							
Total	Met	=	6	X	1	=	6
	Not Met	=	8	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	14	**Total Score**		=	6

Total Score ÷ Total Applicable	=	**43%**

Access Standards: Appointment Times Checklist

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
Primary Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: 2.6.5.3.2; 2.6.5.3.3 PIHP Contract: NA	1. *MCO:* a. *PCP appointments are available as follows:* i. *Non-urgent sick primary care: 72 hours* ii. *Non-urgent routine primary care: 6 weeks* *PAHP:* a. *Primary dental care: within 30 days* b. *Follow-up dental services: within 30 days after assessment* **Evidence as submitted by the MCE:** • C5a_1_Appt Standards; entire document • C5a_1_Provider Manual Narrative; entire document • C5a_1_Provider Manual; pages 9-11	Y ☐ N ☒ NA ☐
Specialty Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Amendment 2, Attachment F PAHP Contract: 2.6.5.3; 2.6.2.7 PIHP Contract: None	2. *MCO:* a. *For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide*: b. *Specialist appointments: one month* c. *Non-urgent routine behavioral health care: 14 days* d. *Urgent non-emergency behavioral health care: 48 hours* e. *ASAM Level 3.3, 3.5, and 3.7: 10 business days* f. *Residential withdrawal management: 24 hours when medically necessary* g. *Psychiatric Residential Treatment Facility (PRTF): 20 calendar days*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	PAHP: a. *Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows:* i. *Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;* ii. *Primary dental care: within 30 days* iii. *Follow-up dental services: within 30 days after assessment* *PIHP:* a. *Urgent non-emergency behavioral health care: 48 hours*	
	Evidence as submitted by the MCE: • C5a_2_Prov Net Dev Plan; pages 4-5 • C5a_1_Provider Manual Narrative; entire document • C5a_1_Provider Manual; pages 9-11	
Hospital and Emergency Services Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: 2.6.5.3 PIHP Contract: 6.3.1.2.2.1	3. *MCO:* a. *Emergency care: 24 hours, 7 days/week within one hour of request* b. *Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request* c. *After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes* *PAHP:* a. *Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;* *PIHP:* a. *Emergent care: 24 hours, 7 days/week within one hour of request*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	b. *Emergent, crisis or emergency services must be available at all times.* c. *Urgent care: 24 hours, 7 days/week within 48 hours of request*	
	Evidence as submitted by the MCE: • C5a_2_Prov Net Dev Plan; pages 4-5 • C5a_1_Appt Standards; entire document • C C5a_1_Provider Manual Narrative; entire document • C5a_1_Provider Manual; pages 9-11	
Prenatal Care and Family Planning Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA	4. *MCO:* a. *OB/GYN care for pregnant women:* i. *1st trimester: 14 days* ii. *2nd trimester: 7 days* iii. *3rd trimester: 3 days* iv. *High risk pregnancy, any trimester: 3 days* b. *Family planning appointments: 1 week*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • C5a_2_Prov Net Dev Plan; pages 4-5 • C5a_1_Appt Standards; entire document • C C5a_1_Provider Manual Narrative; entire document • C5a_1_Provider Manual; pages 9-11	
Office Waiting Times		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)	5. *MCO:* *PAHP:* *PIHP:*	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
MCO Contract: None PAHP Contract: None PIHP Contract: None	**Evidence as submitted by the MCE:** • C5a_2_Prov Net Dev Plan; pages 4-5	

Access Standards: Member-to-Provider Ratio Checklist

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	1. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000* 2. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000* **Evidence as submitted by the MCE:** • C5b_1_ Adult PCP; page 1 • C5b_2_Pediatric PCP; page 1	Y ☒ N ☐ NA ☐
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: None PAHP Contract: None PIHP Contract: None	3. *Acute Inpatient Hospitals* **Evidence as submitted by the MCE:** • C5b_3_Acute Inpatient Hospital; entire document	Y ☐ N ☐ NA ☒
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	4. *Laboratory* 5. *Radiology* 6. *Pharmacy* 7. *Hemodialysis Centers* **Evidence as submitted by the MCE:** • C5b_4_Laboratory; entire document	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
	• C5b_5_Radiology; entire document • C5b_6_Pharmacy; entire document • C5b_7_Hemodialysis Centers; entire document	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	8. *OB/GYN: 1:10,000* 9. *Allergy/Immunology: 1:100,000* 10. *Cardiology: 1:20,000* 11. *Dermatology: 1:40,000* 12. *Endocrinology and Metabolism: 1:25,000* 13. *Gastroenterology: 1:30,000* 14. *Hematology/Oncology: 1:80,000* 15. *Nephrology: 1:50,000* 16. *Neurology: 1:35,000* 17. *Ophthalmology: 1:20,000* 18. *Orthopedics: 1:15,000* 19. *Otorhinolaryngology/Otolaryngology: 1:30,000* 20. *Urology: 1:30,000*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • C5b_8_OBGYN; page 2 • C5b_9_Allergy; page 2 • C5b_10_Cardiology; page 2 • C5b_11_Dermatology; page 2 • C5b_12_Endocrinology; page 2 • C5b_13_Gastroenterology; page 2 • C5b_14_Hematology; page 2 • C5b_15_Nephrology; page 2	

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
	• C5b_16_Neurology; page 2 • C5b_17_Ophthalmology; page 2 • C5b_18_Orthopedics; page 2 • C5b_19_Otolaryngology; page 2 • C5b_20_Urology; page 2	
Linkage Ratio Standards		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	21. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:2,500* **Evidence as submitted by the MCE:** • C5b_21_Adult PCP Narrative; entire document	Y ☒ N ☐ NA ☐
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	22. *Adult Physician Extenders: 1:1,000* **Evidence as submitted by the MCE:** • C5b_22_Adult Physician Extenders; entire document	Y ☒ N ☐ NA ☐
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	23. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1: 2,500* **Evidence as submitted by the MCE:** • C5b_23_Pediatric PCP Narrative; entire document	Y ☒ N ☐ NA ☐

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	24. *Pediatric Physician Extenders: 1: 1,000* **Evidence as submitted by the MCE:** • C5b_24_Pediatric Physician Extenders; pages 1-2	Y ☒ N ☐ NA ☐

Access Standards: Time/Distance Checklist

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Primary Care		

42 CFR §438.207(a)
42 CFR §438.207 (b)(1-2)
42 CFR §457.1218
Contract
 	
MCO Contract: Attachment F
PAHP Contract: 2.6.2.6.1
PIHP Contract: None
	1. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):*
	   a. *Rural Parishes: 30 miles*
	   b. *Urban Parishes: 10 miles*
	2. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):*
	   a. *Rural Parishes: 30 miles*
	   b. *Urban Parishes: 10 miles*
	3. *Primary Dental Services:*
	   a. *Rural Parishes: 30 miles one-way*
	   b. *Urban Parishes: 10 miles*
	
	Evidence as submitted by the MCE:
	• C5c_1_Adult PCP; pages 10-13
	• C5c_1_PCP; pages 14-17
	• C5c_3_Primary Dental; entire document
	• C5c_Checklist Narrative; entire document
		Y ☐ N ☒ NA ☐

Hospitals		

42 CFR §438.207(a)
42 CFR §438.207 (b)(1-2)
42 CFR §457.1218
Contract
 	
MCO Contract: Attachment F
PAHP Contract: None
PIHP Contract: None
	4. *Acute Inpatient Hospitals*
	   a. *Rural Parishes: 30 miles*
	   b. *Urban Parishes: 10 miles*
	
	Evidence as submitted by the MCE:
	• C5c_4_Acute Inpatient Hospitals; page 25-28
		Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	5. *Laboratory:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 20 miles* 6. *Radiology:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 20 miles* 7. *Pharmacy:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 10 miles* 8. *Hemodialysis Centers:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 10 miles* **Evidence as submitted by the MCE:** • C5c_5_Laboratory; pages 29-32 • C5c_6_Radiology; pages 33-36 • C5c_7_Pharmacy; pages 37-40 • C5c_8_Hemodialysis Centers; pages 41-44	Y ☐ N ☒ NA ☐
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F	9. *OB/GYN:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 15 miles* 10. *Allergy/Immunology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
PAHP Contract: 2.6.2.6.2 PIHP Contract: None	11. *Cardiology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 12. *Dermatology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 13. *Endocrinology and Metabolism:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 14. *Gastroenterology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 15. *Hematology/Oncology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 16. *Nephrology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 17. *Neurology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 18. *Ophthalmology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 19. *Orthopedics:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	20. *Otorhinolaryngology/Otolaryngology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 21. *Urology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 22. *Psychiatrists:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 15 miles* 23. *Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 24. *Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 25. *Specialty Dental Services* a. *Travel distance shall not exceed 60 miles one-way from the enrollee's place of residence for at least 75% of enrollees.*	
	Evidence as submitted by the MCE: • C5c_9_OBGYN; pages 49-52 • C5c_10_Allergy; pages 53-56 • C5c_11_Cardiology; pages 57-60 • C5c_12_Dermatology; pages 61-64 • C5c_13_Endocrinology; pages 65-68	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	• C5c_14_Gastroenterology; pages 69-72 • C5c_15_Hematology; pages 73-76 • C5c_16_Nephrology; pages 77-80 • C5c_17_Neurology; pages 81-84 • C5c_18_Ophthalmology; pages 85-88 • C5c_19_Orthopedics; pages 89-92 • C5c_20_Otolaryngology; pages 93-96 • C5c_21_Urology; pages 97-100 • C5c_22_Behavioral Health; pages 2-3 • C5c_22_Behavioral Health; pages 4-5 • C5c_22_Behavioral Health; pages 6-7 • C5c_25_Specialty Dental Services; entire document	
Licensed Mental Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	26. *Behavioral Health Specialist: Advanced Practice Registered Nurse (APRN) with a behavioral health specialty; Medical or Licensed Psychologist; Licensed Clinical Social Worker (LCSW)* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • C5c_22_Behavioral Health; pages 8-9	Y ☐ N ☒ NA ☐
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	27. *PRTF; PRTF Addiction (American Society of Addiction Medicine [ASAM] Level 3.7); PRTF Other Specialization* *a. Rural and Urban Parishes: 200 miles*	Y ☒ N ☐ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	**Evidence as submitted by the MCE:** • C5c_22_Behavioral Health; pages 12-13	
Substance Abuse and Alcohol Abuse Center - Outpatient		

42 CFR §438.207(a)
42 CFR §438.207 (b)(1-2)
42 CFR §457.1218
 	
MCO Contract: Amendment F
PAHP Contract: None
PIHP Contract: None
	28. *ASAM Level 1:*
	  a. *Rural Parishes: 30 miles*
	  b. *Urban Parishes: 15 miles*
	29. *ASAM Level 2.1:*
	  a. *Rural Parishes: 30 miles*
	  b. *Urban Parishes: 15 miles*
	30. *ASAM Level 2WM:*
	  a. *Rural Parishes: 60 miles*
	  b. *Urban Parishes: 60 miles*
	
	Evidence as submitted by the MCE:
	• C5c_22_Behavioral Health; pages 14-15
	• C5c_22_Behavioral Health; pages 16-17
	• C5c_22_Behavioral Health; pages 18-19
		Y ☐ N ☒ NA ☐

Substance Use Residential Treatment Facilities (adult)		

42 CFR §438.207(a)
42 CFR §438.207 (b)(1-2)
42 CFR §457.1218
Contract
 	
MCO Contract: Amendment F
PAHP Contract: None
	31. *ASAM Levels 3.1*
	  a. *Rural Parishes: 30 miles*
	  b. *Urban Parishes: 30 miles*
	32. *ASAM Levels 3.3*
	  a. *Rural Parishes: 30 miles*
	  b. *Urban Parishes: 30 miles*
		Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
PIHP Contract: None	33. *ASAM Levels 3.5* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 30 miles* 34. *ASAM Levels 3.2-Withdrawal Management* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 35. *ASAM Level 3.7* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 36. *ASAM Level 3.7-Withdrawal Management* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles*	
	Evidence as submitted by the MCE: • C5c_31_ASAM Levels 3.1; pages 20-21 • C5c_22_Behavioral Health; pages 24-25 • C5c_22_Behavioral Health; pages 26-27 • C5c_34_ASAM Levels 3.2 W-D Mgmt; pages 22-23 • C5c_22_Behavioral Health; pages 28-29 • C5c_22_Behavioral Health; pages 30-31	
Substance Use Residential Treatment Facilities (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F	37. *ASAM Level 3.1* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 38. *ASAM Level 3.2 Withdrawal Management* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
PAHP Contract: None PIHP Contract: None	39. *ASAM Level 3.5* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* **Evidence as submitted by the MCE:** • C5c_22_Behavioral Health; pages 20-21, 32-33 • C5c_22_Behavioral Health; pages 22-23, 34-35 • C5c_22_Behavioral Health; pages 36-37	
Psychiatric Inpatient Hospital Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	40. *Hospital, Free Standing Psychiatric Unit; Hospital, Distinct Part Psychiatric Unit* *a. Rural Parishes: 90 miles* *b. Urban Parishes: 90 miles* **Evidence as submitted by the MCE:** • C5c_22_Behavioral Health; pages 40-41	Y ☐ N ☒ NA ☐
Behavioral Health Rehabilitation Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	41. *Mental Health Rehabilitation (MHR) Agency (Legacy MHR); Behavioral Health Rehab Provider Agency (Non-Legacy MHR)* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • C5c_22_Behavioral Health; pages 38-39	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Behavioral Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.1; 6.3.1.1.1.2	42. *For the PIHP, behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • Not applicable	Y ☐ N ☐ NA ☒
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.3	43. *For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):* *a. Rural Parishes: 90 miles* *b. Urban Parishes: 60 miles* **Evidence as submitted by the MCE:** • Not applicable	Y ☐ N ☐ NA ☒

Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care Coordination and Services		
Under 42 CFR §438.208(a)(2) For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in 42 CFR §438.208(c).		
1. The MCE ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member is provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.1; 2.8.1.4.2 PAHP Contract: None PIHP Contract: 7.2.5.2	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or member notice • Primary care provider (PCP) assignment algorithm • Screenshot of member identification (ID) card • Screenshot of fields designating the assigned PCP and assigned case manager • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_1.1_Welcome Calls P&P; pages 2 & 3 • S6_1.1_CM PD; pages 7, 8, 25 & 26 • S6_1.2_CM PD; page 7 • S6_1.3_Member Handbook; pages 8, 9, 12 & 13 • S6_1.4_PCP Assignment Algorithm, entire document	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• S6_1.5_Member Handbook; page 4 • S6_1.6_PCP & CM Assignments; entire document • S6_1.7_Member Handbook; pages 8 & 9	
MCE Description of Process: Humana ensures that each member has an ongoing source of care by assigning a Primary Care Provider (PCP) who is responsible for coordinating the member's healthcare services. Members are informed of their designated PCP, including contact information, through their Member ID card and welcome materials. Additionally, members receive guidance on how to change their PCP if needed and are provided with contact information for Member Services, ensuring they can easily reach out for assistance with care coordination or to address any concerns regarding their healthcare needs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE coordinates the services the MCE furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. b. With the services the member receives from any other MCO, PIHP, or PAHP. c. With the services the member receives in fee-for-service (FFS) Medicaid. d. With the services the member receives from community and social support providers. MCO: a. *Coordinate care between network PCPs and specialists, including specialized behavioral health providers;*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Transition of care program • Workflow for coordinating with other MCOs/ PIHPs/PAHPs • Workflow for coordinating with FFS • Workflow for coordinating with community and social support resources • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_2.1_COC Review Dates; entire document	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
b. *Coordinate care for out-of-network services, including specialty care services;* c. *Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;* d. *Coordinate with the court system and State child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed.* PAHP: a. Coordination with the enrollee's MCO: i. *for oral health issues exceeding the coverage of the Contract;* ii. *for transportation to and from covered dental services; and* iii. *regarding value-added dental benefits offered by the enrollee's MCO.* PIHP: a. *Coordination with the Office of Citizens with Developmental Disabilities (OCDD) for the behavioral health needs of the intellectual and developmental disabilities (I/DD) co-occurring population.* b. *Coordinate care for out-of-network services.* c. *Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.* d. *Coordinate timely with Integrated Medicaid Managed Care Programs and the member's family following an*	• S6_2.1_CM PD; pages 4, 5, 9, 15, 16, 17, 18 & 19 • S6_2.1_COC Transitions P&P; pages 1-6 • S6_2.1_TC Role Process Tool; pages 1-3 • S6_2.2_CM PD; pages 4, 5, 9, 15-21, 24-26 • S6_2.3_TOC Program Narrative; entire document • S6_2.3_TC Role Process Tool; pages 1-3 • S6_2.3_CM PD; pages 4, 5, 9, 15-19 • S6_2.3_COC Transitions P&P; pages 1-7 • S6_2.4_MCO Workflow Narrative; entire document • S6_2.5_Workflow for coordinating with FFS Narrative; entire document • S6_2.5_Weekly PA Report Process; entire document • S6_2.6_CM PD; pages 4-6, 9-11, 14-21, 23-26 • S6_2.6_TC Role Process Tool; pages 2-4 • S6_2.6_Program Assignment & Referrals; 9, 10, 16-21 **Additional Documentation:** • 6_2_LA.CLI.013 Continuity of Care and Care Transitions	

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
inpatient, psychiatric residential treatment facility (PRTF), nursing facility, or other residential stay for members when a return to home placement is not possible. 42 CFR §438.208(b)(2) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.3; 2.8.1.4.4; 2.8.1.4.5; 2.8.1.4.10 PAHP Contract: 2.4.7.1; 2.4.6.2.1.3; 2.4.6.2.1.4; 2.4.6.2.1.5 PIHP Contract: 7.2.4; 7.2.5.5; 7.2.5.6; 7.2.5.7		
MCE Description of Process: Humana ensures comprehensive coordination of services for members by facilitating transitions between different care settings, such as from hospital to home, through effective discharge planning. The organization works collaboratively with other health plans and providers to share essential information and manage authorizations, ensuring continuity when members move between managed care organizations or receive services from both managed care and fee-for-service Medicaid. Regular and systematic communication, including secure data transfers and reporting, supports the exchange of relevant health information. Additionally, Humana coordinates care across its provider network—including primary care, specialists, behavioral health providers, and out-of-network services—as well as with community resources and social support agencies. This collaborative approach extends to working with the court system and child-serving agencies to ensure members, especially youth, have access to the full range of needed services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. MCO: a. *The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care. These*	**HSAG Required Evidence:** **Evidence as Submitted by the MCE:** • S6_3_CM PD; pages 5-9, 16-24 & 26 • S6_3_Program Assignment & Referrals; pages 6-18 & 20	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
procedures shall address Enrollees with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services. 42 CFR §438.208(b)(4) 42 CFR §457.1230(c) MCO Contract: 2.8.2.7; 2.8.2.8 PAHP Contract: None PIHP Contract: 7.2.5.8		
MCE Description of Process: Humana has established systematic processes to ensure that information regarding member identification and assessment is shared with the State and other health plans or agencies serving the member, which helps prevent redundant assessments and supports continuity of care. The care management team documents comprehensive assessments and care plans in an integrated system, which can be accessed and shared as needed with authorized partners, including behavioral health and primary care providers. These procedures include clear referral pathways and coordination protocols for members with co-occurring medical and behavioral health needs, such as children with special health care needs, to ensure all relevant agencies and providers are informed of the member's status and needs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Information Sharing		
4. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities MCO: a. *Upon written request* 42 CFR §438.208(b)(4)	**HSAG Required Evidence:** • Policies and procedures • Workflow for sharing assessment results with the State • Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs • Care management program description	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1230(c) MCO Contract: 2.8.1.4.6 PAHP Contract: None PIHP Contract: 7.2.5.8; 7.2.6.1.2	• Three examples of sharing assessment results with the State and/or appropriate MCOs, PIHPs, and/or PAHPs **Evidence as Submitted by the MCE:** • S6_4.1_COC-TOC Process P&P; entire document • S6_4.1_COC Narrative; entire document • S6_4.2_COC of Care Workflow; entire document • S6_4.3_COC of Care Workflow; entire document • S6_4.4_CM PD; pages 4, 5, 8, 11, 15-20, 24, 25 • S6_4.5_COC Narrative; entire document **Additional Documentation:** • 6_2_LA.CLI.013 Continuity of Care and Care Transition • 6_4_CM TOC HHHLA to Other MCO • 6_4_CM TOC Other MCO to HHHLA • 6_4_PA TOC HHHLA to FFS • 6_4_PA TOC HHHLA to Other MCO • 6_4_PA TOC Other MCO to HHHLA	
MCE Description of Process: Humana has established protocols to ensure that, upon written request, the results of any member identification and assessment are promptly shared with the State or other relevant health entities involved in the member's care. The care management team documents all assessments and updates in a centralized system, which allows for efficient retrieval and secure sharing of information. This collaborative approach helps to prevent the duplication of assessment activities and supports continuity and coordination of care for members served by multiple organizations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
5. The MCE ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.7 PAHP Contract: 2.4.8.1; 2.4.8.2; 2.4.8.3.1 PIHP Contract: 16.15	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Provider materials, such as the provider manual and provider contract • Results of medical record reviews (MRR) or other oversight mechanisms for monitoring provider health record practices **Evidence as Submitted by the MCE:** • S6_5.1_CM PD; pages 15, 16, 18, 20, 22-26 • S6_5.1_COC Transitions P&P; pages 1-6 • S6_5.1_GC Meetings; page 1 • S6_5.2_CM PD; pages 15, 16, 18, 20, 22-26 • S6_5.2_COC Transitions P&P; pages 1-7 • S6_5.2_GC Meetings; page 1 • S6_5.3_Provider Manual; page 68 • S6_5.4_Provider Quality Review Process; entire document • S6_5.4_Health Record Review Strategy; entire document • S6_5.4_Provider Quality Monitoring; pages 2-9, 11-15 • S6_5.4_Health Record Review Tool; entire document	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• S6_5.4_Pass Letter; entire document **Additional Documentation:** • 6_5, 12_Provider Manual Email • 6_5, 12_Provider Manual Email 2	
MCE Description of Process: Humana ensures that all providers maintain comprehensive and accurate member health records according to professional standards. Providers are expected to document all services rendered, referrals, and follow-up care in the member's health record. These records are reviewed periodically by Humana's Quality Improvement team to ensure compliance and promote high-quality care. When appropriate, providers share pertinent health information with other treating professionals to support coordinated and continuous care for members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. 42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E MCO Contract: 2.8.2.2.4; 2.9.11.5.1.7; 6.22 PAHP Contract: 2.1.4.1; 2.6.9.5.21 PIHP Contract: 20.12	**HSAG Required Evidence:** • Policies and procedures • Care management program description **Evidence as Submitted by the MCE:** • S6_6.1_Member Outreach Prep Tool; pages 2, 4 & 5 • S6_6.1_Notice of Privacy Practices Policy; entire document • S6_6.1_Call Etiquette & Transfers; page 3 • S6_6.1_CM PD; pages 7, 8, 12 & 22 • S6_6.1_GC PHI-POA-ROI; pages 3, 4 & 8 • S6_6.2_Call Etiquette & Transfers; page 3	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• S6_6.2_CM PD; pages 7, 8, 12 & 22 • S6_6.2_GC PHI-POA-ROI; pages 3, 4 & 8 • S6_6.2_Member Outreach Prep Tool; pages 2, 4 & 5	
MCE Description of Process: Humana protects each member's privacy throughout the care coordination process by strictly following all federal and state privacy requirements. Procedures are in place to ensure that Protected Health Information (PHI) is only accessed, used, and disclosed with appropriate consent, and all associates receive training in HIPAA compliance and privacy best practices. Members are provided with clear information on their privacy rights and how their health information may be used or shared. Regular audits and policy reviews are also part of the process to help ensure ongoing compliance and safeguard sensitive information.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Initial Health Risk Screening		
7. The MCE makes a best effort to conduct an initial screening of each member's needs within MCO: a. 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *The MCO shall attempt to conduct, and document its efforts to conduct, the health needs assessment on at least three (3) different occasions, at different times of the day and on different days of the week.* PAHP: a. *The DBPM shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee's enrollment to conduct an initial screening of the enrollee's needs and to offer to schedule the*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Initial screening template • Initial screening tracking and monitoring mechanisms and subsequent results/reports • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_7.1_Follow Up Outreach Checklist; pages 1 • S6_7.1_CM Role Process; pages 1 & 2	☐ Met ☒ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
enrollee's initial appointment with the primary dental provider (PDP), which should occur within one hundred eighty (180) days of enrollment. 42 CFR §438.208(b)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.2.2 PAHP Contract: 2.4.5.3.1 PIHP Contract: NA	• S6_7.1_UTC Closure Process; entire document • S6_7.1_Welcome Calls P&P; pages 1 & 2 • S6_7.1_CM PD; pages 8, 10 & 17 • S6_7.2_Follow Up Outreach Checklist; page 1 • S6_7.2_CM Role Process; pages 1 & 2 • S6_7.2_UTC Closure Process; entire document • S6_7.2_Welcome Calls P&P; pages 1 & 2 • S6_7.2_CM PD; pages 8, 10 & 17 • S6_7.3_Follow Up Outreach Checklist; page 1 • S6_7.3_CM Role Process; pages 1 & 2 • S6_7.3_UTC Closure Process; entire document • S6_7.3_Welcome Calls P&P; pages 1 & 2 • S6_7.3_CM PD; pages 8, 10 & 17 • S6_7.3_HNA; pages 1-4 • S6_7.4_Screening & Monitoring Mechanisms; entire document	
MCE Description of Process: Humana conducts an initial screening of each new member's needs by reaching out promptly after enrollment to complete a Health Needs Assessment (HNA). If the first outreach attempt is unsuccessful, Humana makes at least two additional attempts, ensuring calls are made at different times of the day and on different days of the week, and all efforts are thoroughly documented. The process is closely monitored using a tracking system and dashboard to ensure timeliness and compliance.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that HUM had policies, procedures, and mechanisms to conduct the initial health needs assessment (HNA); however, results from the virtual case management performance evaluation (CMPE) file review demonstrated noncompliance with timely completion of the initial HNA.		
Required Actions: The MCE must conduct an initial screening of each member's needs within 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. Additionally, the		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCE shall attempt to conduct, and document its efforts to conduct, the HNA on at least three different occasions, at different times of the day, and on different days of the week. Furthermore, the MCE must evaluate its oversight process to ensure the timely completion of the initial HNA. This process must include HNA time frame monitoring, defined frequency of oversight, tools/reports being utilized, and expectation for staff follow up. Case management system flags, queues, or reports that monitor these requirements should be considered.		
Comprehensive Assessment		
8. The MCE implements mechanisms to comprehensively assess each Medicaid member identified by the State and identified to the MCE by the State as needing long-term services and supports (LTSS) or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of the State or MCO as appropriate. PAHP: a. *The PAHP shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high service utilization, intensive dental care needs, or who consistently access services at the highest level of care.* 42 CFR §438.208(c)(2) 42 CFR §457.1230(c) MCO Contract: 2.7.3.1 PAHP Contract: 2.4.6.2.2 PIHP Contract: 7.1.4.1	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Documentation (e.g., program description, quality strategy, etc.) defining members with special healthcare needs and members needing LTSS • Comprehensive assessment template • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_8.1_CM PD Comp Assessment; pages 4, 8, 11, 12, 16, 17 & 23 • S6_8.1_Comp Assessment Narrative; entire document • S6_8.2_CM PD Comp Assessment; pages 4, 8, 11, 12, 16, 17 & 23 • S6_8.3_CM PD; pages 16 & 17 • S6_8.4_Adult Comp; questions 21, 22, 32-34, 42, 54 & 107 • S6_8.4_Pediatric Comp; questions 21, 22, 26-28, 34, 44, 142 & 149	☐ Met ☒ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana utilizes a structured and thorough assessment process to identify the ongoing needs of Medicaid members requiring long-term services and supports or those with special health care needs. Comprehensive assessments are completed in person by qualified care management professionals and include review of the member's physical, behavioral, social, and environmental health status. The assessment incorporates input from the member, caregivers, and appropriate providers to ensure all relevant conditions and care requirements are identified. This process ensures that any ongoing special conditions are recognized and addressed through regular care planning and monitoring, supporting effective care coordination and optimal member outcomes. Documentation of findings and care plans is maintained and updated as needed to reflect changes in the member's condition or preferences.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that HUM had policies, procedures, and mechanisms to conduct initial comprehensive assessments and timely in-person reassessments; however, results from the CMPE file review demonstrated noncompliance with the completion of timely in-person reassessments.		
Required Actions: The MCE must conduct an in-person quarterly reassessment of each member's needs as required by assessed tier level, including subsequent attempts if the initial attempt to contact the member is unsuccessful. Additionally, the MCE shall attempt to conduct, and document its efforts to conduct, the in-person assessment on at least three different occasions, at different times of the day and on different days of the week, and/or document the member's refusal to complete the reassessment in person. Furthermore, the MCE must evaluate its oversight process to ensure the timely completion of in-person reassessments. This process must include reassessment monitoring, defined frequency of oversight, tools/reports being utilized, and expectation for staff follow up. Case management system flags, queues, or reports that monitor these requirements should be considered.		
Treatment/Service Plan		
9. The MCE produces a treatment or service plan for members who require LTSS and, if the State requires, members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. 42 CFR §438.208(c)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.8.1	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Person centered treatment plan template • HSAG will also use the results of the case file reviews	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: None PIHP Contract: 7.1.4.3	**Evidence as Submitted by the MCE:** • S6_9.1_GC Care Plan Tool; pages 1 & 2 • S6_9.1_CM PD; pages 11, 21, 24 & 25 • S6_9.2_CM PD; pages 11, 21, 24 & 25 • S6_9.3_Care Plan Template; entire document	
MCE Description of Process: Humana develops a comprehensive Plan of Care (POC) for members identified as requiring long-term services and supports or those with special health care needs. The POC is created following an in-person assessment and includes a review of the member's physical, social, financial, and behavioral health status. The plan outlines specific, measurable goals with identified interventions, prioritizes member preferences, and addresses strengths and barriers related to each goal. Progress is regularly monitored and documented, with the POC updated as the members' needs or circumstances change. Members receive a copy of their plan and are engaged in ongoing review and acknowledgment to ensure the care plan remains relevant and effective.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance with the timely completion of a plan of care (POC).		
Required Actions: No action required.		
10. The treatment or service plan is: a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member. b. Developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans. c. Approved by the MCE in a timely manner, if this approval is required by the MCE.	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff qualifications for developing care plans and service plans (e.g., job description) • Service plan approval process • Mechanisms to actively involve the member and the member's formal and informal supports in the development of the treatment plan • Mechanisms to actively involve the member's PCP (and any other providers involved in the	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
d. In accordance with any applicable State quality assurance and utilization review standards. 42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c) MCO Contract: 2.7.8.2 PAHP Contract: None PIHP Contract: 7.1.4.3	member's care) in the development of the treatment plan • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_10.1_Careplan Training; slide 11 • S6_10.1_GC Care Plan Tool; pages 1 & 2 • S6_10.1_CM PD; pages 24 & 25 • S6_10.2_CM PD; pages 24 & 25 • S6_10.3_Licensure List; entire document • S6_10.3_Dashboard of Licensure; entire document • S6_10.3_Field CM Nurse Job Descriptions; entire document • S6_10.3_Field CM Behavioral Health Job Descriptions; entire document • S6_10.3_LTSS Narrative; entire document • S6_10.4_CM PD; pages 24 & 25 • S6_10.4_GC Care Plan Tool; pages 1 & 2 • S6_10.5_CM PD; pages 11 & 24 • S6_10.5_GC Care Plan Tool; page 1 • S6_10.6_MDT Meeting 2024; entire document • S6_10.6_CM PD; pages 1, 2, 4-6, 11, 12 & 16	
MCE Description of Process: Humana ensures that treatment or service plans are developed by qualified professionals, such as Field Care Managers who hold appropriate licensure and training in person-centered planning. Each plan is created with the active participation of the		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
member and, when applicable, in consultation with the members' healthcare providers to ensure all needs and preferences are addressed. The care plan process follows a structured, person-centered approach, including identification of individualized goals, interventions, and progress monitoring, as outlined in the Plan of Care Overview and the Louisiana CM GuidingCare Care Plan Tool. Plans are approved and updated according to established schedules and protocols, in compliance with state quality assurance and utilization review requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance in development of POCs that were person-centered and included goals, risks, behavioral health, and supports.		
Required Actions: No action required.		
11. The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3). 42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Care plan and service plan review and revision tracking mechanism • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • S6_11.1_Reassessment Training Presentation; pages 7-9 & 13 • S6_11.1_CM PD; pages 13-15, 24 & 25 • S6_11.1_GC Scripts Tool; page 3 • S6_11.1_Quarterly Reassessment; question 25 • S6_11.2_CM PD; pages 13-15 • S6_11.3_Service Plan Review & Revision Mechanism; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana conducts systematic reviews and revisions of each member's treatment or service plan upon reassessment of functional need, ensuring updates occur at least every 12 months, when significant changes in the member's circumstances or needs are identified, or at the member's request. The review process utilizes a standardized quarterly reassessment tool to capture any changes		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
in health status, medications, providers, support systems, and social determinants of health. All updates are documented in the member's chart, and a comprehensive tracking system monitors due dates and completion of care plan reviews and reassessments.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance with conducting timely POC updates.		
Required Actions: No action required.		
Direct Access to Specialists		
12. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the MCE must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. 42 CFR §438.208(c)(4) 42 CFR §457.1230(c) MCO Contract: 2.9.12.7 PAHP Contract: 2.4.6.2.1.2 PIHP Contract: 7.1.4.1	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or benefits grid • Provider materials, such as the provider manual or provider contracts **Evidence as Submitted by the MCE:** • S6_12.1_UM PD; page 10 • S6_12.1_CM PD; pages 4, 22 & 26 • S6_12.2_CM PD; pages 4, 5, 22, 25 & 26 • S6_12.3_Member Handbook; pages 9, 11, 14-16 • S6_12.4_Provider Manual; page 47 • S6_12.4_Provider Manual Narrative; entire document **Additional Documentation:** • 6_5, 12_Provider Manual Email • 6_5, 12_Provider Manual Email 2	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana Healthy Horizons in Louisiana ensures that members with special health care needs, as identified through assessment, have direct access to specialists when ongoing treatment or regular care monitoring is required. The plan offers mechanisms such as standing referrals or approval for a specified number of specialist visits, tailored to the member's condition and individualized needs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VI—Coordination and Continuity of Care							
Total	Met	=	10	X	1	=	10
	Not Met	=	2	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	12	**Total Score**		=	10

Total Score ÷ Total Applicable	=	**83%**

Standard VII—Coverage and Authorization of Services

<table>
<tr><th colspan="3">Standard VII—Coverage and Authorization of Services</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><th colspan="3">Coverage</th></tr>
<tr><td rowspan="2">1. The MCE:
a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer.
b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B.
c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose.
42 CFR §438.210(a)(1-2)
42 CFR §438.210(a)(3)(i)
42 CFR §440.230
42 CFR §441 Subpart B
42 CFR §457.1230(d)
MCO Contract: 2.4.1.1; 2.4.1.2; 2.4.1.3
PAHP Contract: 2.4.1.4
PIHP Contract: 4.1.2; 4.1.7</td><td>HSAG Required Evidence:
• Policies and procedures
• Member materials, such as the member handbook and benefits grid
• Utilization Management (UM) program description
• Coverage guidelines/criteria</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S7_1.1_Covered Benefits and Services, pages 1-2
• S7_1.2_Member Handbook, pages 14, 20, 31
• S7_1.3_2024 UM PD, pages 7,13,21
• S7_1.4_EPSDT Work Process, entire document
• S7_1.4_Coverage and Authorization of Services, entire document
• S7_1.4_Multi-Systemic Therapy Example, entire document</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana Healthy Horizons in Louisiana utilizes a comprehensive process for reviewing authorization requests to ensure services are delivered appropriately and in line with established medical necessity criteria. The plan relies on clinical coverage policies, provider and member manuals, and recognized clinical guidelines to define and specify the amount, duration, and scope of each covered service, including Multi-Systemic Therapy (MST). All requests are reviewed to confirm that services are provided in a manner consistent with those available under fee-for-service Medicaid, particularly for members under age 21. By adhering to evidence-based criteria and regularly updating policies, Humana ensures that each service offered is sufficient to meet members’ needs and effectively achieve its intended purpose.</td></tr>
</table>

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d) MCO Contract: 2.4.1.3 PAHP Contract: 2.5.1.1 PIHP Contract: 4.1.8	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • S7_2.1_LA Narrative_Clinical PP, entire document • S7_2.1_Timeliness of UM Determinations, pages 4-5 • S7_2.1_2024 UM PD, page 13 • S7_2.2_2024 UM PD, page 13 • S7_2.3_2024 UM PD, page 13	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that all service authorization decisions are based on medical necessity and not solely on a member's diagnosis, type of illness, or condition. The process involves a thorough review of each request using established clinical guidelines and evidence-based criteria, ensuring fair and individualized consideration for every member. Authorization determinations are made by qualified clinical staff who evaluate each case on its specific merits and required documentation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or on utilization control procedures, provided that:	**HSAG Required Evidence:** • Policies and procedures • Utilization management plan • Member materials, such as the member handbook	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCO, PAHP, and PIHP: a. The services furnished can reasonably achieve their purpose. MCO and PIHP: a. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects the member's ongoing need for such services and supports. b. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. 42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d) MCO Contract: 2.4.1.4 PAHP Contract: 2.5.1.2 PIHP Contract: 4.1.10	• Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • S7_3.1_2024 UM PD, page 11 • S7_3.1_LA Narrative_Clinical PP, entire document • S7_3.1_Covered Benefits and Services, page 1 • S7_3.2_2024 UM PD, page 11 • S7_3.3_Member Handbook, page 41 • S7_3.4_Coverage and Authorization of Services, entire document • S7_3.4_Multi-Systemic Therapy Example, entire document	
MCE Description of Process: Humana establishes appropriate limits on services by applying criteria such as medical necessity and utilization control procedures as outlined by the State plan. All services are reviewed to ensure they are likely to achieve their intended purpose and are sufficient in amount, duration, and scope to meet members' needs. For individuals with ongoing or chronic conditions, or those requiring long-term services and supports, authorizations are made in a way that reflects their continued need for care. Additionally, family planning services are provided in a manner that fully respects and enables each member's freedom to select their preferred method of family planning.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
4. The MCE specifies what constitutes “medically necessary services” in a manner that: a. Is no more restrictive than that used by the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses the extent to which the MCE is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member’s disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. 42 CFR §438.210(a)(5) MCO Contract: 2.4.1.6 PAHP Contract: 2.5.2.6; 2.5.2.7 PIHP Contract: 4.1.10; 4.1.11	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S7_4.1_Covered Benefits and Services, pages 1,3 • S7_4.1_LA Narrative_Clinical PP, entire document • S7_4.1_Coverage and Authorization of Services, entire document • S7_4.2_Covered Benefits and Services, pages 1,3 • S7_4.2_2024 UM PD, pages18,21 • S7_4.2_LA Narrative_Clinical PP, entire document • S7_4.3_Member Handbook, page 14-15,31-32 • S7_4.4_Provider Manual, page 26 – 43, 43 – 44, 45, 46, 48, 51, and 88 • S7_4.4_LA Narrative_Provider Manual, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana defines “medically necessary services” in alignment with the standards set by the Louisiana Medicaid program, ensuring that criteria are no more restrictive than those used by the State. The definition incorporates both quantitative and non-quantitative treatment limits, as outlined in state statutes, regulations, and the Medicaid State Plan. Humana is responsible for covering services that prevent, diagnose, and treat diseases, conditions, or disorders that result in health impairments or disabilities, as well as supporting members in achieving age-appropriate growth and development. Additionally, services are provided to help members attain, maintain, or regain functional capacity, as guided by evidence-based medical standards and the specific needs of each individual.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Authorization of Services		
5. The MCE and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. 42 CFR §438.210(b)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.3.6.1 PAHP Contract: 2.5.2.1.1.5 PIHP Contract: 7.5.2.1	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • List of delegated entities performing utilization management • Delegated written contract (for entities responsible for delegated UM functions) • Delegation oversight of policies and procedures (e.g., audit results) **Evidence as Submitted by the MCE:** • S7_5.1_Clinician Processing Authorizations, entire document • S7_5.1_Completing Inpatient Concurrent Review, entire document • S7_5.1_ Completing Clinical Review CGX, entire document • S7_5.1_ Completing Preservice Inpatient Reviews, entire document • S7_5.2_2024 UM PD, pages 9 - 16; 19 -21 • S7_5.3_Clinician Processing Authorizations, entire document	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7_5.4_List of Delegated Entities, entire document • S7_5.5_Coverage and Authorization of Services, entire document • S7_5.6_Coverage and Authorization of Services, entire document **Additional Documentation:** • Clinician Inpatient Denial Auditor Checklist • Clinician Outpatient Approval Auditor Checklist • Clinician Inpatient Approval Associate Auditor Checklist • Clinician Outpatient Denial Associate Auditor Checklist • Genesys UM Associate Audit Checklist • Network Medical Review JOC Meeting presentations (all months of 2024)	
MCE Description of Process: Humana maintains comprehensive, written policies and procedures to guide the processing of requests for both initial and continuing authorization of services. The process involves careful review of all relevant clinical documentation and application of standardized clinical criteria by qualified professionals to ensure determinations are based on medical necessity and appropriateness. All reviews and authorizations are fully documented in the clinical system, with clear timelines for decision-making and notification to providers and members. These policies are reviewed regularly and updated as needed to ensure consistent, equitable access to medically necessary care and to support ongoing quality improvement efforts. For further details, see Humana Healthy Horizons in Louisiana's Utilization Management Program Description and associated work processes.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
6. The MCE has in effect mechanisms to ensure consistent application of review criteria for authorization decisions. 42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d) MCO Contract: 2.12.4.1; 2.12.6 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Results of inter-rater reliability (IRR) activities **Evidence as Submitted by the MCE:** • S7_6.1_Inter-rater Reliability, entire doc • S7_6.2_2024 UM PD, pages 5, 23-24 • S7_6.3_Multi-Systemic Therapy Example, entire document • S7_6.3_Coverage and Authorization of Services, entire document • S7_6.3_Medical Necessity Criteria Guidelines, entire document • S7_6.4_Coverage and Authorization of Services, entire document **Additional Documentation:** • NCQA Quality & IRR Standards Trends • Network Medical Review JOC Meeting presentations (all months of 2024) • Clinician Inpatient Denial Auditor Checklist • Clinician Outpatient Approval Auditor Checklist • Clinician Inpatient Approval Associate Auditor Checklist • Clinician Outpatient Denial Associate Auditor Checklist	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Genesys UM Associate Audit Checklist • Network Medical Review JOC Meeting presentations (all months of 2024)	
MCE Description of Process: Humana ensures the consistent application of review criteria for authorization decisions through several established mechanisms. All clinical staff involved in utilization management undergo annual inter-rater reliability (IRR) testing, which assesses their ability to apply medical necessity criteria uniformly across cases; those who do not meet the required competency standard receive targeted retraining and retesting. The plan utilizes standardized clinical coverage policies and evidence-based guidelines, with regular audits of cases to confirm adherence to these standards. Additionally, review decisions are documented thoroughly, and ongoing education and oversight are provided to staff to support consistency in decision-making.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. The MCE consults with the requesting provider for medical services when appropriate. 42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Three case examples of peer-to-peer consults **Evidence as Submitted by the MCE:** • S7_7.1_UM Determinations Notifications Timeframes, entire document • S7_7.1_Peer to Peer Process, page 1 • S7_7.1_Coverage and Authorization of Services, entire document • S7_7.2_2024 UM PD, page 5, 16-17 • S7_7.3_LA Narrative_Provider Manual, entire document	☐ Met ☐ Not Met ☒ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7_7.3_Provider Manual, page 47 • S7_7.4_Coverage and Authorization of Services, entire document	
MCE Description of Process: Humana ensures that consultation with the requesting provider for medical services occurs as part of the utilization management process when appropriate. Providers may contact the Utilization Management (UM) staff by phone or email to discuss authorization requests and clinical determinations and are encouraged to request a peer-to-peer discussion with a physician reviewer if there is a question regarding an adverse determination.		
HSAG Findings: HSAG has scored this element as not applicable since State requirements differ from federal requirements. In the virtual review, HUM staff members described that when a prior authorization request is denied by a reviewer (such as medical director), the provider is issued a notice of adverse benefit determination (ABD) via fax and letter which informs the provider of the right to request a peer-to-peer (within a specified time frame). A notice of ABD is also sent to the member at this point in time (prior to the peer-to-peer). If requested, a peer-to-peer consultation is scheduled, and if the denial decision is overturned, that is noted in the member record and the service is approved. At this point, all the notifications are regenerated indicating approval. HUM's documentation and its description of this process during the virtual review indicated that it has an informal reconsideration process as per its contract with LDH. However, CMS has articulated that MCEs' practice of adjusting prior authorization denial decisions based on peer-to-peer discussions occurring after the MCE sends a member a notice of ABD is inconsistent with Medicaid managed care regulations and, rather, is consistent with CMS' definition of an appeal. HSAG has communicated this information to LDH.		
Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		
8. The MCE authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Authorization workflow for LTSS • UM program description • Coverage guidelines/criteria • Three examples of authorized LTSS and copies of the corresponding person-centered service plans	☐ Met ☐ Not Met ☒ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S7_8.1_Coverage and Authorization of Services, entire document • S7_8.2_Coverage and Authorization of Services, entire document • S7_8.3_Coverage and Authorization of Services, entire document • S7_8.4_Coverage and Authorization of Services, entire document • S7_8.5_Coverage and Authorization of Services, entire document	
MCE Description of Process: Humana Healthy Horizons in Louisiana currently does not offer Long-Term Services and Supports (LTSS). As such, the process for authorizing LTSS based on a member's current needs assessment and alignment with a person-centered service plan is not applicable at this time.		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No required action.		
9. The MCE ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health. MCO: a. *The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an Enrollee's condition or disease and training in the use of any required assessments shall*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Job descriptions for UM decision makers • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_9.1_2024 UM PD, pages 6-8	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
determine Service Authorization request denials or authorize a service in an amount, duration or scope that is less than requested. PAHP: a. *Made by a licensed dentist, as appropriate, or other professional as approved by LDH, who has appropriate clinical experience in treating the enrollee's condition.* 42 CFR §438.210(b)(3) 42 CFR §457.1230(d) MCO Contract: 2.12.5.2 PAHP Contract: 2.5.6.1.1 PIHP Contract: 7.5.2.3	• S7_9.2_2024 UM PD, pages 7-8 • S7_9.3_UM Behavioral Health Job Description, entire document • S7_9.3_PH Medical Director Job Description, entire document • S7_9.3_UM Coordinator Job Description, entire document • S7_9.3_BH Medical Director Job Description, entire document • S7_9.3_UM Nurse Job Description, entire document	
MCE Description of Process: Humana ensures that all decisions to deny a service authorization request, or to approve a service in an amount, duration, or scope less than requested, are made exclusively by licensed clinical professionals with the appropriate expertise and training relevant to the member's condition. For medical authorizations, determinations are conducted by licensed registered nurses or physicians; for behavioral health services, licensed mental health professionals or board-certified psychiatrists review and render decisions.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Notice of Adverse Benefit Determination		
10. The MCE notifies the requesting provider of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. MCO: a. *The MCO shall provide written notification to the provider rendering the service, whether a health care*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider notice template • HSAG will also use the results of the Service Authorization Denial File Review	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
professional or facility or both, within two (2) Business Days of making the determination. PIHP: a. *The notification shall include an explanation describing the reason(s) for authorization of a service in an amount, duration, or scope that is less than requested. The PIHP shall notify the provider rendering the service, verbally as expeditiously as the member's health condition requires, but not more than one (1) business day of making the initial determination and shall provide written confirmation of such notification to the provider within two (2) business days of making the initial determination.* 42 CFR §438.210(c) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.7.1 PIHP Contract: 7.8.5.3.2	**Evidence as Submitted by the MCE:** • S7_10.1_Time Frame Matrix; page 6 • S7_10.1_Peer to Peer; page 1 • S7_10.2_UMPD; page 13 • S7_10.3_Partial Denial Template; entire document	
MCE Description of Process: Humana ensures timely and clear communication to providers regarding service authorization decisions. When a request is denied or approved in an amount, duration, or scope less than requested, Humana sends a written notification to the provider rendering the service within two business days of the determination. This notification includes a comprehensive explanation of the decision, the criteria used, and guidance on next steps, such as appeal or peer-to-peer review options. The process is outlined in the Partial Denial Template and UM Determinations Notifications Timeframes documents, which detail the steps and timeframes for provider notification.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
11. The MCE defines an adverse benefit determination (ABD) as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. d. The failure to provide services in a timely manner, as defined by the State. e. The failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one MCE, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network. g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. 42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7) 42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S7_11.1_Timeliness UM Determination; page 3 • S7_11.2_Member Handbook; page 6 • S7_11.3_Provider Manual; pages 23-24, 28, 62-63	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard VII—Coverage and Authorization of Services</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>MCO Contract: Glossary
PAHP Contract: Glossary
PIHP Contract: 11.2.1</td><td></td><td></td></tr>
<tr><td colspan="3">MCE Description of Process: Humana defines an adverse benefit determination (ABD) as any decision that negatively impacts a member's access to services or benefits. This includes the denial or limitation of a requested service, reductions or terminations of previously authorized services, and denials of payment for services except when related to incomplete claims. An ABD also encompasses failures to provide services or issue decisions within required timeframes, as well as denials related to members' requests to access out-of-network care in specific rural situations or to dispute financial liabilities such as copayments or deductibles.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td>12. The MCE gives members written notice of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following:
a. The ABD the MCE has made or intends to make.
b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
c. The member's right to request an appeal of the MCE's ABD, including information on exhausting the MCE's one level of appeal, described at 42 CFR §438.402(b),</td><td>HSAG Required Evidence:
• Policies and procedures
• UM program description
• ABD notice template with taglines
• HSAG will also use the results of the Service Authorization Denial File Review

Evidence as Submitted by the MCE:
• S7_12.1_Timeliness UM Determination; pages 4-5
• S7_12.2_UMPD; page 17
• S7_12.3_Partial Denial Template; entire document
• S7_12.3_Denial Template; entire document

Additional Documentation:
• Member Material Requirements
• LA MCD Denial Checklist</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
</table>

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
and right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.402(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services. g. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.4 PIHP Contract: 11.3.2		
MCE Description of Process: Humana provides members with a detailed written notice when a service authorization request is denied or approved in an amount, duration, or scope less than requested. This notice clearly states the adverse benefit determination made, along with the specific reasons for the decision and informs members of their right to request, free of charge, copies of all documents, records, and criteria used in making the determination. The notice also explains the member's right to appeal the decision, outlines the procedures for filing an appeal, and provides information on requesting a State fair hearing if the appeal is not resolved in the member's favor. Additionally, it describes the process for requesting an expedited appeal, the right to continue receiving benefits during the appeal process, and the conditions under which members may be responsible for service costs if the final decision is not in their favor.		

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<tr><th colspan="3">Standard VII—Coverage and Authorization of Services</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. File review demonstrated that notices of ABD did not meet state-required reading levels. In the virtual review, HUM staff described a new process it was implementing to ensure notices of ABD meet all requirements and submitted documentation of the draft process.</td></tr>
<tr><td colspan="3">Required Actions: The MCE must finalize its process and procedures to ensure its notices of ABD meet state-required reading levels.</td></tr>
<tr><th colspan="3">Timeframe for Decisions</th></tr>
<tr><td>13. For standard authorization decisions, the MCE provides notice as expeditiously as the member’s condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service.
42 CFR §438.210(d)(1)
42 CFR §438.404(c)(3)
42 CFR §457.1230(d)
42 CFR §457.1260(c)(3)
MCO Contract: 2.12.6.1.2
PAHP Contract: 2.5.7.2.1
PIHP Contract: 11.3.3.1.5</td><td>HSAG Required Evidence:
• Policies and procedures
• UM program description
• Tracking and reporting mechanisms
• Service authorization log(s) within the time period under review
• HSAG will also use the data from the universe file
• HSAG will also use the results of the Service Authorization Denial File Review

Evidence as Submitted by the MCE:
• S7_13.1_Timeliness UM Determination; pages 1-2
• S7_13.2_UMPD; page 13
• S7_13.3_Narrative; entire document
• S7_13.3_Timeliness Report Example; entire document
• S7_13.3_0188 Act 421 2024 Q1; entire document
• S7_13.3_0188 HUM 2024 Q1; entire document
• S7_13.3_0188BH Act 421 2024 Q1; entire document
• S7_13.3_0188BH HUM 2024 Q1 Resubmit; entire document</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
</table>

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures that standard authorization decisions are made and communicated to members as quickly as their clinical condition requires and always within the state-mandated timeframe of no more than 14 calendar days from receipt of the service request. The process includes tracking and reporting the timeliness of each authorization decision, with daily and quarterly monitoring to ensure compliance with all required turnaround times. A request is considered complete only when the member is notified of the determination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
14. For cases in which a provider indicates, or the MCE determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later 72 hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.2.1 PAHP Contract: 2.5.7.2.3 PIHP Contract: 11.3.3.1.8	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_14.1_Timeliness UM Determination; page 3 • S7_14.2_UMPD; pages 13-14 • S7_14.3_Timeliness Report Example; entire document • S7_13.3_Narrative; entire document • S7_13.3_Timeliness Report Example; entire document • S7_13.3_0188 Act 421 2024 Q1; entire document	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7_13.3_0188 HUM 2024 Q1; entire document • S7_13.3_0188BH Act 421 2024 Q1; entire document • S7_13.3_0188BH HUM 2024 Q1 Resubmit; entire document • S7_14.4_Expedited 2024 Auth Reqs; entire document • S7_14.4_Narrative; entire document • S7_14.4_0188 Act 421 HUM 2024 Q1; entire document	
MCE Description of Process: Humana has established processes to ensure expedited authorization decisions are made when a provider indicates, or it is determined, that the standard timeframe could jeopardize a member's life, health, or ability to function. In such situations, the plan makes an expedited decision and provides notification as quickly as the member's condition requires, but always within 72 hours of receiving the request. Compliance with these requirements is actively monitored through daily timeliness reports, and the data is also reviewed quarterly to ensure ongoing adherence. This systematic approach ensures that members receive timely access to urgent services and that regulatory expectations are met, as described in the Utilization Management Program Description.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if: a. The member, or the provider, requests the extension; or b. The MCE justifies to the State agency upon request a need for additional information and how the extension is in the member's interest.	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • Three case examples of authorizations with an extension, including the date of receipt of the	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.1.3 PAHP Contract: 2.5.7.2.4 PIHP Contract: 11.3.3.1.5; 11.3.3.1.9	authorization request and date of the decision to extend the time frame • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_10.1_Time Frame Matrix; entire document • S7_14.1_Timeliness UM Determination; pages 2-3 • S7_14.2_UMPD; pages 13-14 • S7_15.3_Narrative; entire document • S7_15.3_Timeliness Report Example; entire document • S7_15.4_UM Notice of Ext Letter Draft; entire document • S7_15.5_Examples of Ext Reqs; entire document	
MCE Description of Process: Humana Healthy Horizons in Louisiana has processes in place to extend the resolution time frame for both standard and expedited authorization decisions by up to 14 additional calendar days when requested by the member or provider, or when the plan justifies the need for additional information in the member's best interest. All extensions are tracked and reported quarterly to the Louisiana Department of Health (LDH) through the 188 Report, which documents the timeliness and occurrence of any extensions. Notification letters are sent to members and providers to communicate the extension, its reason, and the revised decision due date. Monitoring mechanisms, such as daily timeliness reports, ensure compliance with regulatory requirements and support transparency. As of the latest reporting, there have been no extension requests received from providers or members, as documented in the 188 reports submitted to LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
16. If the MCE meets the criteria set forth for extending the timeframe for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it: a. Gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and b. Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d) MCO Contract: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • Three case examples of authorizations with an extension, including the written notice of the extension • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_16.1_Timeliness UM Determination; pages 2, 3 & 4 • S7_16.1_Processing Authorization; pages 1 & 2 • S7_15.4_UM Notice of Ext Letter Draft; entire document • S7_16.2_UMPD; page 13 • S7_13.3_Timeliness Report Example; entire document • S7_13.3_0188 Act 421 2024 Q1; entire document • S7_13.3_0188 HUM 2024 Q1; entire document • S7_13.3_0188BH Act 421 2024 Q1; entire document • S7_13.3_0188BH HUM 2024 Q1 Resubmit; entire document	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7_16.3_Narrative • S7_15.4_UM Notice of Ext Letter Draft; entire document • S7_16.5_Examples of Ext Reqs	
MCE Description of Process: Humana Healthy Horizons in Louisiana follows a defined process for extending the timeframe for standard and expedited service authorization decisions when allowed by regulation. When an extension is granted, members receive a written notice explaining the reason for the extension and are informed of their right to file a grievance if they disagree with the decision. The notice also provides the revised decision due date and assures the member that the determination will be made as quickly as their health condition requires, but no later than the expiration of the extension period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA). a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. 42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A) MCO Contract: None PAHP Contract: NA PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • UM program description • Three examples of notice **Evidence as Submitted by the MCE:** • S7_17.1_UM Prime Procedure; page 3 • S7_17.2_UMPD Narrative; entire document • S7_17.3_Example 1; entire document • S7_17.3_Example 2; entire document • S7_17.3_Example 3; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana Healthy Horizons in Louisiana ensures compliance with requirements for covered outpatient drug authorization decisions by providing notice as outlined. Specifically, for any request for prior authorization of outpatient drugs, a response is delivered to the requesting provider by telephone or other telecommunication device within 24 hours. This timely communication helps		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
facilitate prompt access to necessary medications for members. The process is addressed through policies implemented by Humana's Pharmacy Benefits Manager, Prime Therapeutics.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
18. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCE mails the ABD notice to the member within at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214. 42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1	**HSAG Required Evidence:** • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • Three case examples of advance notices, including the ABD notice and the effective date of decision • HSAG will also use the data from the universe file • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the MCE:** • S7_18.1_Timeliness UM Determination; pages 4-5 • S7_18.1_Denial Letter Tasking; pages 1-2 • S7_18.2_UMPD Narrative; entire document • S7_18.3_Denial Letter Template; entire document • S7_18.4_Reporting Narrative; entire document • S7_18.5_Examples Narrative; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana Healthy Horizons in Louisiana ensures compliance by mailing an Adverse Benefit Determination (ABD) notice to members at least 10 days prior to the termination, suspension, or reduction of previously authorized Medicaid-covered		

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Requirement	**Supporting Documentation**	**Score**
services. The ABD notice includes a clear explanation of the action, the specific reasons for the decision, and information about the member's rights to appeal or request a fair hearing. The notice also provides details on how to obtain additional information, how to request continued benefits during an appeal, and how to file a grievance if needed. This process ensures transparency and gives members sufficient time to respond before any changes to their services take effect. For 2024, there were no cases identified that required this type of notice, as referenced in the reporting documentation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
19. The MCE may send a notice not later than the date of action if: a. The MCE has factual information confirming the death of a member; b. The MCE receives a clear written statement signed by a member that: i. The member no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member's whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address; e. The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member that meets one of the criteria of this element (one example must apply to a deceased member, one example must apply to a member who no longer wishes to receive services, and one example must apply to a member who is no longer eligible for services through the MHP) • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_19.1_Timeliness UM Determination; pages 4-5 • S7_19.2_UMPD Narrative; entire document	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
f. A change in the level of medical care is prescribed by the member's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i). 42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §483.15(b)(4)(i-ii) 42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.2 PIHP Contract: 11.3.3.1.3	• S7_19.2_UMPD Policy; entire document • S7_19.3_Denial Letter Template; entire document • S7_19.3_Narrative; entire document • S7_19.4_Reporting Narrative; entire document • S7_19.4_Timeliness_MockUp; entire document • S7_19.4_Timeliness Report Example; entire document • S7_19.5_Examples Narrative; entire document	
MCE Description of Process: Humana Healthy Horizons in Louisiana complies with requirements for expedited notice in specific situations outlined by regulation, such as confirmation of a member's death, a member's written request to terminate services, admission to an ineligible institution, or other qualifying scenarios. In these instances, Humana utilizes the standard Adverse Benefit Determination (ABD) notice template provided by the Louisiana Department of Health (LDH), ensuring the notice is sent no later than the date of action as permitted. When applicable, the reason for the determination is clearly stated in the free text section of the notice, and the process is tracked using the daily Timeliness Report to monitor compliance with contractual timeframes. Although Humana has not encountered these scenarios frequently, the established process and use of LDH-approved templates ensure readiness to meet all regulatory requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
20. The MCE may shorten the period of advance notice to five days before the date of action if: a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.1 PIHP Contract: 11.3.3.1.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member due to probable fraud • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_20.1_UM Job Aid; entire document • S7_20.2_UMPD; page 17 • S7_20.3_Denial Letter Template • S7_20.3_Narrative; entire document • S7_20.4_Reporting Narrative; entire document • S7_20.5_Examples Narrative; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana Healthy Horizons in Louisiana is prepared to comply with requirements that allow the period of advance notice to be shortened to five days before the date of action when there are verified facts indicating probable fraud by a member. In such instances, the plan utilizes the standard Adverse Benefit Determination (ABD) notice template provided by the Louisiana Department of Health, including specific language in the free text section to explain the reason for the determination. While there is not a dedicated tracking mechanism for fraud-related denials, any such determination would follow the outlined process, ensuring clear and timely communication to the affected member. To date, there have been no reports or examples of fraud by members necessitating this shortened notice period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
21. The MCE mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.2 PIHP Contract: 11.3.3.1.4	**HSAG Required Evidence:** • Policies and procedures • Workflow/guidelines for payment denial on a claim to trigger ABD notice • UM program description • ABD notice template for denial of payment • Tracking and reporting mechanism(s) • Three case examples of the denial of payment on a claim, including date of the denial and ABD notice • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • S7_21.1_Timeliness UM Determination; page 4 • S7_21.2_Claims Narrative; entire document • S7_21.3_UMPD Narrative; entire document • S7_21.3_Timeframe Matrix; page 6 • S7_21.3_Timeliness UM Determination; page 4 • S7_21.4_NABD EN; entire document • S7_21.4_NABD SP; entire document • S7_21.5_Narrative; entire document • S7_21.5_Cycle Time Report; entire document	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• S7_21.5_NOA Report; entire document • S7_21.6_Claim Example 1; entire document • S7_21.6_Claim Example 2; entire document • S7_21.6_Claim Example 3; entire document	
MCE Description of Process: Humana Healthy Horizons in Louisiana ensures that an Adverse Benefit Determination (ABD) notice is mailed to members promptly whenever there is a denial of payment affecting a claim. The notice clearly outlines the denied service, the reason for denial, and informs the member of their rights to free documentation, appeal, and request a State fair hearing. Both members and providers receive notification, ensuring transparency and enabling informed next steps. Compliance with these requirements is monitored through two monthly metric reports: one tracking notification compliance and another tracking cycle times.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
22. For standard and expedited service authorization decisions not reached within the required timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the MCE provides notice on the date that the timeframes expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Service authorization log(s) within the time period under review • Tracking and reporting mechanism(s) • Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S7_22.1_Timeliness UM Determination; page 4 • S7_22.2_UMPD; page 13 • S7_22.3_Untimely Denial Letter; entire document • S7_22.4_Narrative • S7_13.3_0188 Act 421 2024 Q1; entire document • S7_13.3_0188 HUM 2024 Q1; entire document • S7_13.3_0188BH Act 421 2024 Q1; entire document • S7_13.3_0188BH HUM 2024 Q1 Resubmit; entire document • S7_13.3_Timeliness Report Example • S7_22.6_Example 1; entire document • S7_22.6_Example 2; entire document • S7_22.6_Example 3; entire document • S7_22.6_Example Narrative; entire document	
MCE Description of Process: Humana Healthy Horizons in Louisiana ensures that when standard or expedited service authorization decisions are not completed within the required timeframes, this is considered a denial and triggers an Adverse Benefit Determination (ABD). In such cases, the plan issues an ABD notice to the member on the same date that the required timeframe expires. This notice clearly explains the reason for the untimely decision, outlines the member's appeal rights, and provides instructions on how to access further information or file a grievance. The process is closely monitored through daily timeliness reports, and examples of ABD notices demonstrate compliance with this requirement.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Compensation for Utilization Management Activities		
23. The MCE provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d) MCO Contract: 2.12.5.1 PAHP Contract: 2.5.1.4 PIHP Contract: 6.8.5.27	**HSAG Required Evidence:** • Policies and procedures • UM program description • New hire and ongoing training for staff • Three examples of staff attestations **Evidence as Submitted by the MCE:** • S7_23.1_UMPD; page 5 • S7_23.3_Narrative; entire document • S7_23.4_Attestation Narrative; entire document • S7_23.4_Attestation 1; entire document • S7_23.4_Attestation 2; entire document • S7_23.4_Attestation 3; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana Healthy Horizons in Louisiana affirms, through signed attestations from key clinical and utilization management leaders, that compensation for individuals or entities conducting utilization management activities is not structured to incentivize the denial, limitation, or discontinuation of medically necessary services. Leadership and staff, including the Director of Clinical Services, Associate Director of Utilization Management, and a UM Nurse Reviewer, each attest they have no knowledge of such compensation practices either in the past or present. These attestations are formalized and documented, providing assurance that compensation arrangements are compliant with regulatory requirements and focused solely on the appropriate delivery of medically necessary care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VII—Coverage and Authorization of Services							
Total	Met	=	20	X	1	=	20
	Not Met	=	1	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	21	**Total Score**		=	20

Total Score ÷ Total Applicable	=	**95%**

Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCE implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. MCO: For the MCOs, additional requirements must be followed according to 2.9.30.1, 2.9.30.3 in the MCO Contract, and in the MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff. 42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.9.29.3; 2.9.30.1; 2.9.9.4; 2.9.30.3; MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff PAHP Contract: 2.6.9.11 PIHP Contract: 6.8.3	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • S8_1_Cred and Recred Policy; pages 27 & 28 **Additional Documentation:** • 8_1_LA.NNO.002 Prov Net Dev + Manage Plan	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana maintains comprehensive, written policies and procedures for the selection and retention of network providers, ensuring that all credentialing and recredentialing activities are conducted in alignment with 42 CFR §438.214. These processes include rigorous verification of provider qualifications, licensure, work history, and exclusion status through primary sources and approved databases. The organization utilizes a peer review-based Credentials Committee to make objective credentialing decisions and implements ongoing monitoring for quality, sanctions, and compliance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
2. The MCE follows a documented process for credentialing and recredentialing of network providers that meets the State requirements for each of the following provider types: a. Acute; b. Primary; c. Mental health; d. Substance use disorders. 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.9.9.2; 2.9.29.4; 2.9.30.1 PAHP Contract: 2.6.9.11.1 PIHP Contract: 6.7.4	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • S8_2_Cred and Recred Policy; pages 1, 3-4	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana utilizes a comprehensive, written process for credentialing and recredentialing network providers, ensuring that acute care, primary care, mental health, and substance use disorder providers all meet rigorous standards for licensure, education, training, and professional conduct. The process includes primary source verification of credentials, ongoing monitoring for sanctions or exclusions, and periodic reassessment at least every three years. Specialized requirements are applied to each provider type, including verification of appropriate certifications and accreditations for behavioral health and addiction services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Nondiscrimination		
3. The MCE network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions	**HSAG Required Evidence:** • Policies and procedures • Nondiscrimination statement for credentialing committee members	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c) 42 CFR §438.12 42 CFR §457.1233(a) MCO Contract: 2.9.9.2; 2.9.29.5 PAHP Contract: 2.6.9.11.2 PIHP Contract: 6.1.16.1	• Mechanism for monitoring for discriminatory practices **Evidence as Submitted by the MCE:** • S8_3.1_Cred and Recred Policy; pages 21-22 • S8_3.2_Nondiscrimination Statement	
MCE Description of Process: Humana's network provider selection policies and procedures are designed to ensure fairness and nondiscrimination in credentialing decisions. The organization explicitly prohibits decisions based on factors such as a provider's race, ethnic or national identity, gender, age, sexual orientation, or the type of patient population served. Providers who care for high-risk populations or who specialize in treating complex or costly conditions are evaluated using the same objective criteria as all other applicants. Regular reviews and oversight help confirm that credentialing decisions are made solely on the basis of professional qualifications and compliance with established standards.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the MCE declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.	**HSAG Required Evidence:** • Policies and procedures • Provider notice template(s) for adverse credentialing and/or contracting decisions • Examples of one individual and one organizational executed provider contracts • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12 (a)(1-2) 42 CFR §438.214 42 CFR §457.1233(a) MCO Contract: 2.9.7.8; 2.9.9.1; 2.9.9.2 PAHP Contract: 2.6.8.1; 2.6.9.10; 2.6.10.1 PIHP Contract: 6.1.12.3; 6.1.16.2; 6.1.17	• HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_4.1_Cred and Recred Policy; pages 24 & 48 • S8_4.1_Provider Manual; page 20 & 21 • S8_4.2_Initial Cred Incomplete Ltr; entire document • S8_4.2_Admin Criteria Denial - Initial App; entire document • S8_4.2_Recon Criteria Denial - Initial App; entire document • S8_4.3_Physician Agreement; entire document • S8_4.3_Ancillary Agreement; entire document • S8_4.4_Cred and Recred Policy; pages 21-22 **Additional Documentation:** • 8_4_Cred + Recred Policy • 8_4_Non-discrimination Committee Agreement	
MCE Description of Process: Humana ensures that its provider credentialing and network participation processes are fair and nondiscriminatory, evaluating all providers solely on objective criteria related to qualifications, experience, and compliance with regulatory standards, rather than on the type of license or certification held. When a provider is not selected for inclusion in the network, Humana issues a written notice clearly stating the specific reasons for the decision, as outlined in its credentialing and recredentialing policies. The organization also provides information on reconsideration or appeal processes when applicable.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. While HUM's credentialing committee nondiscrimination statement included language that referenced the federal requirement, HUM did not have a policy that indicated discrimination is not occurring.		
Required Actions: The MCE must develop a policy that the MCE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the MCE declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision. b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214.		
Excluded Providers		
5. The MCE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. 42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3 MCO Contract: 2.9.8.1; 6.5.6; 2.2.2.1.4 PAHP Contract: 2.6.3.3.1; 2.6.3.3.2; 6.7.3.1 PIHP Contract: 6.8.8; 13.4.3	**HSAG Required Evidence:** • Policies and procedures • Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included) • Three consecutive examples of documentation supporting the monthly screening of providers for sanctions/exclusions (proof of sources must be included) • Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • S8_5.1_Network Participation Reqs; pages 1-2 • S8_5.2_Nov 2024 Example; entire document • S8_5.2_Oct 2024 Example; entire document • S8_5.2_Sept 2024 Example; entire document • S8_5.3_Sept Attestation; entire document • S8_5.3_Exclusion List - Sept 2024; entire document • S8_5.3_Oct Attestation; entire document • S8_5.3_Exclusion List - Oct 2024; entire document • S8_5.3_Nov Attestation; entire document • S8_5.3_Exclusion List - Nov 2024; entire document • S8_5.4_Ongoing Monitoring Narrative; entire document	
MCE Description of Process: Humana maintains direct oversight of its provider network to ensure compliance with federal requirements prohibiting employment or contracting with individuals or entities excluded from participation in federal health care programs under sections 1128 or 1128A of the Social Security Act. The organization does not delegate ongoing monitoring of provider sanctions or exclusions to any external entities, instead conducting these checks internally. By actively performing regular reviews and verifications, Humana promptly identifies and addresses any excluded providers, thereby upholding federal program integrity standards.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
State Requirements		
6. The MCE complies with any additional requirements established by the State. MCO: i. *The MCO, through its Compliance Officer, shall attest monthly to LDH that it has screened all providers as specified in the debarment/suspension/exclusion section or that it has verified and confirmed that the provider is enrolled with the State.* ii. *The Contractor shall report to LDH, within three (3) Business Days, when it has discovered that any Contractor employee(s), Network Provider, Subcontractor, or Subcontractor's employee(s) have been excluded, suspended, or debarred from any State or Federal health care benefit program via the designated LDH Program Integrity contact.* iii. *The Contractor and its Subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even*	**HSAG Required Evidence:** • Policies and procedures • Three consecutive months of attestations submitted to LDH • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_6.1_Cred and Recred Policy; pages 29-30 • S8_6.2_Sept Attestation; entire document • S8_6.2_Oct Attestation; entire document • S8_6.2_Nov Attestation; entire document **Additional Documentation:** • 8_6_Cred + Recred Policy	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
when the Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).] PIHP: a. *An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.* b. *The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) which could result in exclusion, debarment, or suspension of the Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.* 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.20.3.7; 2.20.3.11; 2.20.5.3 PAHP Contract: None PIHP Contract: 13.2.2; 13.2.4		
MCE Description of Process: Humana demonstrates compliance with all additional State requirements by implementing a comprehensive monthly screening process for all providers, employees, and subcontractors against federal and state exclusion and debarment lists, including the OIG LEIE, Louisiana Adverse Actions List, and SAM, as well as any other sites designated by the state. The Compliance Officer attests monthly to the Louisiana Department of Health that these screenings have been completed, as documented in the monthly attestations. In the event any individual or entity is found to be excluded, suspended, or debarred, Humana reports the information to LDH within three business days and takes prompt action to remove such individuals or entities from network participation to prevent prohibited affiliations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. While HUM provided evidence of monthly attestations to LDH, the submitted evidence did not include a formal policy and procedure that outlined the process for reporting to LDH, within three business days, when it has discovered that any contractor employee(s), network provider, subcontractor, or subcontractor's employee(s)		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
have been excluded, suspended, or debarred from any State or federal healthcare benefit program via the designated LDH Program Integrity contact. **Recommendations:** HSAG recommends that HUM incorporate the process into a formal policy and procedure.		
Required Actions: No action required.		
Practitioner Verification of Credentials		
7. For credentialing and recredentialing, the MCE primary source verifies that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 180 calendar days of the credentialing decision. a. *The MCE verifies the license directly from the state licensing or certification agency (or its website).* 42 CFR §438.214(e) MCO Contract: 2.9.7.3; 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3; 2.6.9.2 PIHP Contract: 6.5.6; 6.7.4	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_7.1_Cred and Recred Policy; pages 5-6	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana conducts primary source verification to ensure that each practitioner holds a current and valid license in all states where care is provided to members. This verification is performed directly through the appropriate state licensing or certification agency, including the use of official agency websites when applicable. The process requires that licensure status be confirmed within 180 calendar days prior to the credentialing decision, ensuring accuracy and compliance with established standards.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Practitioner Verification of Credentials		
8. For credentialing and recredentialing, the MCE primary source verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members at the time of the credentialing decision. a. *This requirement does not apply to practitioners who are not qualified to write prescriptions.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_8.1_Cred and Recred Policy; page 6	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that each practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is current and valid in every state where care is provided to members at the time of credentialing and recredentialing. This verification is conducted through primary sources such as the DEA agency, state pharmaceutical licensing agencies, or by visually inspecting the original certificate. If a practitioner does not prescribe controlled substances, they may submit a written statement explaining this, along with their process for handling patient needs related to controlled substances. Practitioners not qualified to write prescriptions are exempt from this requirement.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
9. For credentialing, the MCE verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate prior to the credentialing decision: a. *Board certification;* b. *Residency; or*	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:**	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
c. *Graduation from medical or professional school.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	• S8_9.1_Cred and Recred Policy; page 6	
MCE Description of Process: Humana's credentialing process includes primary source verification of a practitioner's highest level of education and training, ensuring accuracy and compliance with industry standards. Prior to making a credentialing decision, Humana confirms either board certification, completion of residency, or graduation from medical or professional school, as appropriate for the practitioner's specialty. Acceptable sources for verification include official specialty boards, residency training programs, medical or professional schools, and relevant accrediting bodies.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. For credentialing and recredentialing, the MCE verifies the practitioner's board certification status, if applicable, within 180 calendar days of the credentialing decision. a. *Verification of board certification does not apply to nurse practitioners (NPS) or other health care professionals unless the MCO communicates board certification to members.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_10.1_Cred and Recred Policy; pages 27 & 28	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana's credentialing and recredentialing process includes primary source verification of a practitioner's board certification status, when applicable, within 180 calendar days prior to the credentialing decision. Acceptable sources for verification include the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), relevant specialty boards, and state licensing agencies that perform primary source verification. This requirement does not apply to nurse practitioners or other healthcare professionals unless board certification is communicated to members.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. For credentialing, the MCE verifies the practitioner's work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision. a. *If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.* b. *If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The MCE documents a verbal clarification or includes the written notice in the practitioner's credentialing file.* c. *If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_11.1_Cred and Recred Policy; pages 13 & 27	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana's credentialing process includes verification of each practitioner's work history, covering at least the most recent five years or beginning from the initial licensure date if less than five years of experience is available. The organization reviews applications or curricula vitae for any gaps in employment, requiring verbal or written clarification from the practitioner for gaps greater than six months. For gaps exceeding one year, a written explanation is required and maintained in the credentialing file, with the review documented by Humana		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
12. For credentialing and recredentialing, the MCE verifies a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]), that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_12.1_Cred and Recred Policy; pages 13-14, 26 & 47	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Humana ensures that, as part of the credentialing and recredentialing process, a thorough review is conducted on each practitioner's history of professional liability claims. This verification is completed either through direct confirmation with the malpractice carrier or by querying the National Practitioner Data Bank (NPDB), focusing on claims that resulted in a settlement or judgment paid on behalf of the practitioner. The review is performed within 180 calendar days prior to the credentialing decision to ensure the information is current and relevant.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for two practitioner recredentialing case files did not verify compliance with primary source verification requirements, specifically related to required documentation elements.		
Required Actions: For credentialing and recredentialing, the MCE must verify a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]) that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision.		
Practitioner Sanction Information		
13. For credentialing and recredentialing, the MCE verifies the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision.	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
a. *The MCE verifies State sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**Evidence as Submitted by the MCE:** • S8_13.1_Cred and Recred Policy; pages 5, 13, 16 & 49	
MCE Description of Process: Humana's credentialing and recredentialing process includes comprehensive verification of State sanctions, restrictions on licensure, and limitations on scope of practice for each practitioner. This verification is conducted through primary or NCQA-approved sources in all states where the practitioner has provided care to members within the most recent five years, and it is completed within 180 calendar days prior to the credentialing decision.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for one practitioner credentialing case file and one organizational recredentialing case file did not verify compliance with primary source verification requirements. More specifically, the case files did not include verification of the Louisiana Adverse Actions List.		
Required Actions: For credentialing and recredentialing, the MCE must verify the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision. Additionally, the MCE must verify in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.		
14. For credentialing and recredentialing, the MCE verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_14.1_Cred and Recred Policy; pages 14, 17, 27, 28, 29, 46 & 47	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that, as part of its credentialing and recredentialing process, a thorough verification of Medicare and Medicaid sanctions is completed for each practitioner. This verification is conducted through primary or approved sources,		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
including the National Practitioner Data Bank (NPDB), the Office of Inspector General (OIG) exclusion list, and the Louisiana State Adverse Actions List. All sanction checks are performed within 180 days prior to the credentialing decision to ensure accuracy and compliance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Practitioner Credentialing Application/Attestation		
15. For credentialing and recredentialing, the MCE ensures the application and attestation, respectively include: a. *Reasons for inability to perform the essential functions of the position;* b. *Lack of present illegal drug use;* c. *History of loss of license and felony convictions;* d. *History of loss or limitation of privileges or disciplinary actions;* e. *Current malpractice insurance coverage; and* f. *Current and signed attestation confirming the correctness and completeness of the application.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_15.1_Cred and Recred Policy; page 27	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana's credentialing and recredentialing process requires practitioners to complete an application and attestation that comprehensively address key professional and personal qualifications. The application and attestation include disclosures regarding any reasons the practitioner may be unable to perform essential job functions, affirmation of the absence of current illegal drug use, and documentation of any history of license loss, felony convictions, or disciplinary actions impacting privileges. Additionally, practitioners must provide evidence of current malpractice insurance coverage. A signed and dated attestation is required, confirming that all information provided in the application is accurate and complete.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Practitioner Monitoring		
16. The MCE develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identified occurrences of poor quality. The MCE develops and implements ongoing monitoring and makes appropriate interventions by: a. *Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);* b. *Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and* c. *Implementing appropriate interventions when it identifies instances of poor quality.* 2 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • Provider complaints tracking reports • Provider adverse events tracking reports • Credentialing committee meeting minutes • Two examples of interventions taken based on poor quality of care **Evidence as Submitted by the MCE:** • S8_16.1_Cred and Recred Policy; pages 29-30 • S8_16.2_Provider Complaints Tracking; entire document • S8_16.3_Adverse Incidents; entire document • S8_16.4_Corporate Meeting Minutes – Jan; entire document • S8_16.4_Corporate Meeting Minutes – Feb; entire document • S8_16.4_Corporate Meeting Minutes – Mar; entire document • S8_16.4_Corporate Meeting Minutes – April; entire document • S8_16.4_Corporate Meeting Minutes – May; entire document • S8_16.4_Corporate Meeting Minutes – June; entire document	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• S8_16.4_Corporate Meeting Minutes – July; entire document • S8_16.4_Corporate Meeting Minutes – Aug; entire document • S8_16.4_Corporate Meeting Minutes – Sept; entire document • S8_16.4_Corporate Meeting Minutes – Oct; entire document • S8_16.4_Corporate Meeting Minutes – Nov; entire document • S8_16.4_Corporate Meeting Minutes – Dec; entire document • S8_16.5_Example Narrative; entire document **Additional Documentation:** • 8_16_Cred + Recred Policy	
MCE Description of Process: Humana maintains robust policies and procedures to ensure ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles. The organization systematically collects and reviews both complaints and information related to adverse events for all practitioners at least every six months. When potential quality concerns or adverse events are identified, appropriate interventions are implemented, which may include additional monitoring, required remediation, or removal from the network. This ongoing oversight process helps safeguard member safety and ensures a high standard of care across the provider network, as documented in the Credentials Committee meeting minutes and credentialing policies.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not meet the requirements of the element. HUM's policy and procedure did not include language regarding the ongoing monitoring of practitioner complaints and quality issues between recredentialing cycles and how it takes appropriate action against practitioners when it identifies occurrences of poor quality.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must implement policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and take appropriate action against practitioners when it identifies occurrences of poor quality. The MCE must develop and implement ongoing monitoring and make appropriate interventions by: a. Collecting and reviewing complaints (the MCE must evaluate the history of complaints for all practitioners at least every six months); b. Collecting and reviewing information from identified adverse events (the MCE must monitor for adverse events at least every six months); and c. Implementing appropriate interventions when it identifies instances of poor quality.		
Organizational Verification of Credentials		
17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • List of organizational provider types and corresponding licensing body in the State of Louisiana • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_17.1_Cred and Recred Policy; entire document • S8_17.2_Cred and Recred Policy; page 32 • S8_17.2_Licensure Websites; entire document	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Humana's credentialing and recredentialing process includes thorough verification to confirm that each provider is in good standing with all applicable state and federal regulatory bodies. This verification involves checking the provider's current state licensure status, as well as reviewing federal databases such as the Office of Inspector General (OIG) exclusion list, the System for Award Management (SAM), and the National Practitioner Data Bank (NPDB) for any sanctions, exclusions, or disciplinary actions. These checks are completed within specified timeframes prior to the credentialing decision and are documented as part of the provider's credentialing file.		

<table>
<tr><th colspan="3">Standard VIII—Provider Selection</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for one organizational initial credentialing file review did not verify that HUM confirmed the provider was in good standing with State and federal regulatory bodies.</td></tr>
<tr><td colspan="3">Required Actions: For credentialing and recredentialing, the MCE must confirm that a provider is in good standing with State and federal regulatory bodies.</td></tr>
<tr><td rowspan="2">18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body.
a. If the provider is not accredited, the MCE conducts an onsite quality assessment.
i. The MCE has a process for ensuring that the provider credentials their practitioners.
42 CFR §438.214(e)
MCO Contract: 2.9.30.1; 2.9.30.5
PAHP Contract: 2.6.8.1; 2.6.8.3
PIHP Contract: 1.2.1.2.; 6.5.6; 6.7.4; 6.7.6; 6.7.8</td><td>HSAG Required Evidence:
• Policies and procedures
• Onsite assessment review tool/template
• HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review</td><td rowspan="2">☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S8_18.1_Cred and Recred Policy; pages 2, 5-6, 13, 35
• S8_18.2_Cred and Recred Policy; pages 33-34
• S8_18.2_Site Review Temp Narrative; entire document</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures that all providers undergoing credentialing and recredentialing have been reviewed and approved by an accrediting body. If a provider lacks current accreditation or if a CMS or state review is older than three years, Humana conducts its own onsite quality assessment to evaluate the provider’s compliance with quality standards. During this assessment, Humana also verifies that the provider has appropriate processes in place to credential their practitioners. For the review period of January 1, 2024, through December 31, 2024, there were no providers identified as requiring a Humana-conducted onsite quality review, in accordance with established policy and procedures outlined in the site review documentation.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for one organizational initial credentialing file and one organizational recredentialing file did not confirm that providers were reviewed and approved by an accrediting body or that HUM conducted an on-site quality assessment if the provider was not accredited.</td></tr>
</table>

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Required Actions: For credentialing and recredentialing, the MCE must confirm that the provider has been reviewed and approved by an accrediting body. Furthermore, if the provider is not accredited, the MCE must conduct an on-site quality assessment. In addition, the MCE must have a process for ensuring that the provider credentials its practitioners.		
Time Frames		
19. The MCE ensures that the credentialing process provides for mandatory recredentialing at a minimum of every 36 months in accordance with NCQA requirements. 42 CFR §438.214(e) MCO Contract: 2.9.30.14 PAHP Contract: 2.6.8.6 PIHP Contract: 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • Recredentialing timeliness report during the review period • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • S8_19.1_Cred and Recred Policy; pages 15 & 36 • S8_19.2_Report; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that all practitioners and organizational providers are formally recredentialed at least every 36 months, consistent with NCQA standards. The process includes advance notification to providers of their upcoming recredentialing deadline, with at least three written notices sent to the provider's last known email and mailing addresses. All credentialing elements, such as licensure, board certification, work history, and sanctions, are re-verified using primary or NCQA-approved sources prior to the recredentialing decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VIII—Provider Selection							
Total	Met	=	13	X	1	=	13
	Not Met	=	6	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	19	**Total Score**		=	13

Total Score ÷ Total Applicable	=	**68%**

Standard IX—Subcontractual Relationships and Delegation

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the MCE may have with any delegate, MCE maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. 42 CFR §438.230(b)(1) 42 CFR §457.1233(b) MCO Contract: 2.2.3.8; 2.2.3.9 PAHP Contract: 1.4.2; 2.15.3; 2.15.6 PIHP Contract: 1.5.1	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • S9_1_Subcontractor Regulatory Attachment, page 4	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana maintains ultimate responsibility for adhering to all terms and conditions of its contract with the State. While certain functions and responsibilities may be delegated to subcontractors, Humana retains accountability for all delegated activities and ensures full compliance through ongoing monitoring, formal annual reviews, and corrective action plans as needed. This oversight is further supported by clear contractual language stating that subcontracting does not relieve Humana of its legal obligations under the State contract.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • S9_2.1_Subcontractor Regulatory Attachment, page 2	☒ Met ☐ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE's contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or the MCE determine that the delegate has not performed satisfactorily. *42 CFR §438.230(b)(2)* *42 CFR §438.230(c)(1)* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.4.1; 2.2.3.4.2; 2.2.3.4.3 PAHP Contract: 2.15.6.3; 2.15.9 PIHP Contract: 1.5.3.1		
MCE Description of Process: Humana ensures compliance with delegation requirements by incorporating detailed provisions into each contract or written arrangement with its delegates. Each agreement clearly specifies the delegated activities or obligations and associated reporting responsibilities, ensuring alignment with the obligations under Humana's contract with the State. Delegates expressly agree within these agreements to perform all delegated activities and reporting duties in accordance with Humana's contractual obligations to the State. Additionally, the contracts include terms that allow for revocation of delegated activities or implementation of other remedies if either the State or Humana determines the delegate's performance is unsatisfactory.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review	☐ Met ☒ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
MCO: a. *rules, policies, procedures, manuals, the State Plan, and Waivers.* *42 CFR §438.230(c)(2)* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.4.4 PAHP Contract: 2.15.6.3 PIHP Contract: 1.5.3.1	**Evidence as Submitted by the MCE:** • S9_3.1_Subcontractor Regulatory Attachment, page 2	
MCE Description of Process: Humana ensures compliance by requiring that all contracts or written arrangements with delegates, as detailed in the S9_3.1_Subcontractor Regulatory Attachment, explicitly state the delegate's agreement to adhere to all applicable Medicaid laws, regulations, sub regulatory guidance, and contract provisions. Each agreement incorporates, by reference, the relevant federal and state statutes, rules, policies, procedures, manuals, the State Plan, and applicable Waivers, ensuring that delegates are contractually bound to these requirements. Additionally, the document mandates that any revisions to laws or guidance are automatically incorporated into the subcontract as they become effective, thus maintaining ongoing compliance.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's Louisiana Medicaid Subcontractor Regulatory Attachment (SRA), Section 1, contained the following language: "Subcontractor shall comply with all applicable Contract requirements, applicable Federal and State laws—including but not limited to 42 C.F.R. §438.3 as it applies to the services described in the Subcontract—regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and applicable subregulatory guidance." HUM's delegation case file submissions were also used by the HSAG reviewer to evaluate this requirement. HUM's executed SRAs for all three case file submissions contained the same language. HUM's SRA did not comport with the required federal and State language of this requirement, which is exacting.		
Required Actions: The MCE must ensure that all contracts or written arrangements indicate that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and rules, policies, procedures, manuals, the State Plan, and Waivers.		
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS)	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review	☐ Met ☒ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. *42 CFR §438.230(c)(3)* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.5; 2.2.3.5.1; 2.2.3.5.2 PAHP Contract: 2.15.11.1; 2.15.11.1.1; 2.15.11.1.2; 2.15.11.1.3 PIHP Contract: 1.5.3.1	**Evidence as Submitted by the MCE:** • S9_4.1_Subcontractor Regulatory Attachment, page 3	
MCE Description of Process: Humana ensures compliance with audit and oversight requirements by including explicit provisions in its subcontractor agreements. The contract stipulates that the State, CMS, HHS Inspector General, Comptroller General, or their designees have the authority to audit, evaluate, and inspect any books, records, contracts, or electronic systems of the delegate or its subcontractors that relate to services performed or payment determinations under Humana's contract with the State. Delegates are required to make their premises, facilities,		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
equipment, and all relevant records available for such purposes, and this right to audit extends for ten years from the end of the contract period or completion of any audit, whichever is later. Additionally, the agreement provides that in cases where there is a reasonable possibility of fraud or similar risk, these agencies may exercise their right to audit or inspect at any time.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's Louisiana Medicaid Subcontractor Regulatory Attachment (SCA), Section 10(d)(i-iii), contained the following language: "Subcontractor shall comply with the requirements set forth in 42 C.F.R. §438.230(c)(3) regarding audit rights and record retention: The Louisiana state government, including LDH, MFCU, and the Louisiana Legislative Auditor (LLA), and the Federal government, including, CMS, OIG, and the Comptroller General, or their designees, shall have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under this Contract at any time; This right exists, and all documentation and/or records shall be maintained, for ten (10) years from the termination of this Contract for the Subcontractor or from the date of completion of any audit, whichever is later; provided, however that if Subcontractor is determined that there is a reasonable possibility of fraud or similar risk, they may audit, evaluate, and inspect at any time; subcontractor shall make their premises, facilities, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above." HUM's delegation file submissions were also used by the HSAG reviewer to evaluate this requirement. HUM's executed SCAs for all three delegation file submissions contained the same language. HUM's SCAs did not comport with the required federal and State language of this requirement, which is exacting.		
Required Actions: The MCE must ensure that all contract or written arrangements indicate, and the delegate agrees that: a. The State, Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.		

<table>
<tr><th colspan="3">Standard IX—Subcontractual Relationships and Delegation</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>5. The contract or written arrangement:
MCO:
a. Stipulates that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.
42 CFR §438.230
42 CFR §457.1233(b)
MCO Contract: 2.2.3.4.5
PAHP Contract: NA
PIHP Contract: NA</td><td>HSAG Required Evidence:
• Delegation agreement/contract template
• HSAG will also use the results from the Delegation File Review
Evidence as Submitted by the MCE:
• S9_5.1_Subcontractor Regulatory Attachment, page 2</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures compliance by including explicit language in its subcontractor agreements, as required by the S9_5.1_Subcontractor Regulatory Attachment, that stipulates Louisiana law will govern the interpretation and enforcement of the contract, regardless of any conflicting laws from the subcontractor's home state.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><th colspan="3">Monitoring and Auditing</th></tr>
<tr><td>6. Monitoring subcontractor's performance shall be monitored:
MCO:
a. On an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH.
PAHP:
a. On an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.</td><td>HSAG Required Evidence:
• Delegation agreement/contract template
• Monitoring and audit documentation
• Annual formal review
• HSAG will also use the results from the Delegation File Review
Evidence as Submitted by the MCE:
• S9_6.1_Subcontractor Regulatory Attachment, page 4</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
</table>

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *The Subcontractor(s) will provide a written commitment to accept all Contract provisions and to comply with 42 CFR §438.3(k) and §438.230.* *42 CFR §438.230* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.6 PAHP Contract: 2.15.6.4 PIHP Contract: 1.5.3	• S9_6.2_Delegation Monitoring Information, entire spreadsheet • S9_6.3_Network Medical JOC-June 2024, entire document • S9_6.3_Network Medical JOC-August 2024, entire document • S9_6.3_Network Medical JOC-April 2024, entire document • S9_6.3_Network Medical JOC-December 2024, entire document • S9_6.3_Network Medical JOC-February 2024, entire document • S9_6.3_Network Medical JOC-January 2024, entire document • S9_6.3_Network Medical JOC-July 2024, entire document • S9_6.3_Network Medical JOC-March 2024, entire document • S9_6.3_Network Medical JOC-May 2024, entire document • S9_6.3_Network Medical JOC-November 2024, entire document • S9_6.3_Network Medical JOC-October 2024, entire document • S9_6.3_Network Medical JOC-September 2024, entire document • S9_6.3_Dentaquest Adult Dental JOC-Q1 2024, entire document	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• S9_6.3_Dentaquest Adult Dental JOC-Q2 2024, entire document • S9_6.3_Dentaquest Adult Dental JOC-Q3 2024, entire document • S9_6.3_Dentaquest Adult Dental JOC-Q4 2024, entire document • S9_6.3_Merakey JOC April 2024, entire document • S9_6.3_Merakey JOC August 2024, entire document • S9_6.3_Merakey JOC December 2024, entire document • S9_6.3_Merakey JOC January 2024, entire document • S9_6.3_Merakey JOC February 2024, entire document • S9_6.3_Merakey JOC July 2024, entire document • S9_6.3_Merakey JOC June 2024, entire document • S9_6.3_Merakey JOC March 2024, entire document • S9_6.3_Merakey JOC May 2024, entire document • S9_6.3_Merakey JOC November 2024, entire document • S9_6.3_Merakey JOC October 2024, entire document	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• S9_6.3_Merakey JOC September 2024, entire document • S9_6.3_Block Vision dba Superior Vision Claims 2024, entire document • S9_6.3_Block Vision dba Superior Vision Credentialing 2024, entire document • S9_6.3_DentaQuest Claims 2024, entire document • S9_6.3_DentaQuest Credentialing 2024, entire document • S9_6.3_Medi Trans Claims 2024, entire document • S9_6.3_Merakey Care Coordination 2024, entire document • S9_6.3_Network Medical Review Appeal UM 2024, entire document • S9_6.3_Network Medical Review Initial UM 2024, entire document • S9_6.3_Meditrans JOC meeting Oct 2024, entire document • S9_6.3_Meditrans JOC meeting Dec 2024, entire document • S9_6.3_Superior Vision JOC Q4 2024 and Q1 2025, entire document • S9_6.3_Superior Vision JOC Q1 2024, entire document • S9_6.3_Superior Vision JOC Q2 2024, entire document	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• S9_6.3_Superior Vision JOC Q3 2024, entire document • S9_6.3_Meditrans Humana Oversight Jan-July 2024, entire document • S9_6.3_Meditrans Humana Oversight Aug & Sept 2024, entire document • S9_6.3_Meditrans JOC meeting Nov 2024, entire document	
MCE Description of Process: Humana complies with subcontractor performance monitoring requirements by conducting ongoing oversight and performing a formal review of each subcontractor at least annually. The annual review process specifically includes evaluating any performance concerns identified by the LDH, ensuring that all issues are addressed promptly and appropriately. Ongoing monitoring activities include JOC meetings to review performance and concerns, regular audits, performance reporting, and corrective action plans as needed to ensure compliance with contractual and regulatory obligations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	4	X	1	=	4
	Not Met	=	2	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	**Total Score**		=	4

Total Score ÷ Total Applicable	=	**67%**

Standard X—Practice Guidelines

<table>
<tr><th colspan="3">Standard X—Practice Guidelines</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><th colspan="3">Adoption of Practice Guidelines</th></tr>
<tr><td rowspan="2">1. The MCE adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
42 CFR §438.236(b)(1)
42 CFR §457.1233(c)
MCO Contract: 2.12.12.4.1
PAHP Contract: 2.5.5.1.1
PIHP Contract: 7.4.5.2</td><td>HSAG Required Evidence:
• Policies and procedures
• List of adopted practice guidelines
• MCE-specific meeting minutes documenting committee review and approval</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S10_1.1_Clinical Practice Guidelines, pages 1-2
• S10_1.1_CPG Coversheet, page 1
• S10_1.2_Addendum CPG-Dec 2024, entire document
• S10_1.3_CPGPC Meeting Minutes-Dec 2024, entire document
• S10_1.3_QAPI Minutes, pages 63-66
• S10_1.3_CPGPC Meeting Minutes-June 2024, entire document</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana adopts clinical practice guidelines (CPGs) through a structured, multi-step process to ensure they are based on valid and reliable clinical evidence or, when necessary, consensus among relevant providers. The Clinical Practice Guideline Physician Committee (CPGPC), comprising internal and network physicians from diverse specialties, reviews, recommends, and updates CPGs, referencing nationally recognized expert organizations and regularly assessing guideline relevance and applicability. All adopted guidelines are reviewed in consultation with network providers and are updated periodically to reflect new evidence or consensus.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
</table>

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
2. The MCE adopts practice guidelines that consider the needs of the MCE's members and: MCO: a. adopts clinical practice guidelines for at least the conditions listed below: i. Schizophrenia; ii. Attention Deficit Hyperactivity Disorder (ADHD); iii. Autism Spectrum Disorder; iv. Depression; v. Generalized Anxiety Disorder; vi. Post-Traumatic Stress Disorder; vii. Suicidal Behavior; viii. Oppositional Defiant Disorder; ix. Bipolar Disorder; and x. Substance Use Disorders. PIHP: a. develops clinical practice guidelines for: i. ADHD ii. Trauma Informed Care iii. Depression and Conduct Disorder 42 CFR §438.236(b)(2) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.2; 2.12.12.3 PAHP Contract: 2.5.5.1.2 PIHP Contract: 7.4.5.3; 7.4.7.1	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval **Evidence as Submitted by the MCE:** • S10_2.1_CPG Coversheet, page 1 • S10_2.2_Addendum CPG-Dec 2024, entire document • S10_2.3_CPGPC Meeting Minutes-Dec 2024, entire document • S10_2.3_QAPI Minutes, pages 63-66 • S10_2.3_CPGPC Meeting Minutes-June 2024, entire document	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard X—Practice Guidelines</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures compliance with requirements for adopting CPGs by implementing a structured process that considers the specific needs of its members. The organization maintains CPGs for all required behavioral health conditions, including schizophrenia, ADHD, autism spectrum disorder, depression, generalized anxiety disorder, post-traumatic stress disorder, suicidal behavior, oppositional defiant disorder, bipolar disorder, and substance use disorders. These guidelines are selected from nationally recognized sources, regularly reviewed by a multidisciplinary committee—including external network providers—and updated to reflect new evidence and member needs. Additionally, Humana disseminates approved CPGs to providers and monitors adherence through established quality and performance improvement processes.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">3. The MCE adopts practice guidelines that are adopted in consultation with network providers.
42 CFR §438.236(b)(3)
42 CFR §457.1233(c)

MCO Contract: 2.12.12.4.3
PAHP Contract: 2.5.5.1.3
PIHP Contract: 7.4.5.1</td><td>HSAG Required Evidence:
• Policies and procedures
• List of adopted practice guidelines
• MCE-specific meeting minutes documenting committee review and approval
• Evidence of consultation of network providers</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S10_3.1_CPG Coversheet, page 1
• S10_3.1_Clinical Practice Guidelines, page 1
• S10_3.2_Addendum CPG-Dec 2024, entire document
• S10_3.3_CPGPC Meeting Minutes-Dec 2024, entire document
• S10_3.3_QAPI Minutes, pages 63-66
• S10_3.3_CPGPC Meeting Minutes-June 2024, entire document
• S10_3.4_QAPI Minutes, pages 63-66</td></tr>
</table>

<table>
<tr><th colspan="3">Standard X—Practice Guidelines</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCE Description of Process: Humana adopts CPGs through a collaborative and consultative process that actively involves network providers. The Clinical Practice Guideline Physician Committee (CPGPC), comprising internal and external network physicians from various specialties, convenes at least twice annually to review, recommend, and update CPGs based on current evidence and clinical consensus. Recommendations from the CPGPC are then presented to the Corporate Quality Improvement Committee (CQIC) for final approval.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td>4. The MCE adopts practice guidelines that are:
MCO/PAHP:
a. reviewed and updated periodically as appropriate.
PIHP:
a. Reviewed annually and updated periodically as appropriate.
b. Approved by LDH within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines.
42 CFR §438.236(b)(4)
42 CFR §457.1233(c)

MCO Contract: 2.12.12.4.4
PAHP Contract: 2.5.5.1.4
PIHP Contract:7.4.5.4; 7.4.7.2</td><td>HSAG Required Evidence:
• Policies and procedures
• List of adopted practice guidelines; including the last reviewed/revised date for each practice guideline
• MCE-specific meeting minutes documenting committee review and approval, and/or planned meeting schedule and agenda

Evidence as Submitted by the MCE:
• S10_4.1_CPG Coversheet, page 1
• S10_4.1_Clinical Practice Guidelines, page 1
• S10_4.2_Addendum CPG-Dec 2024, entire document
• S10_4.3_CPGPC Meeting Minutes-Dec 2024, entire document
• S10_4.3_QAPI Minutes Q3, pages 63-67
• S10_4.3_CPGPC Meeting Minutes-June 2024, entire document</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures that CPGs are reviewed and updated periodically to maintain alignment with current clinical evidence and regulatory requirements. The CPGPC meets at least biannually to evaluate the relevance and accuracy of existing guidelines,</td></tr>
</table>

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
considering new research, changes in standards of care, and feedback from network providers. Updates and recommendations are documented in committee meeting minutes and submitted to the Corporate Quality Improvement Committee for final approval.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Dissemination of Guidelines		
5. The MCE disseminates the guidelines to: a. All affected providers b. Members and potential members, upon request 42 CFR §438.236(c) 42 CFR §457.1233(c) MCO Contract: 2.12.12.5 PAHP Contract: 2.5.5.3 PIHP Contract: 7.4.7	**HSAG Required Evidence:** • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the MCE:** • S10_5.1_CPG Coversheet, page 2 • S10_5.1_Evidence of Dissemination, entire document • S10_5.2_Evidence of Dissemination-Providers, entire document • S10_5.3_Evidence of Dissemination-Members, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures dissemination of CPGs to all affected providers and to members or potential members upon request through established communication channels. Approved CPGs are made available on the Humana Healthy Horizons in Louisiana website.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Application of Guidelines		
6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236(d) 42 CFR §457.1233(c) MCO Contract: 2.12.12.6 PAHP Contract: 2.5.5.4 PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • Coverage guidelines/criteria • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters) • Three examples of coverage denial notices **Evidence as Submitted by the MCE:** • S10_6.1_LA UM PD 2024, page 4 • S10_6.2_Multi-Systemic Therapy (MST) Example, entire document • S10_6.2_Coverage Guidelines Criteria, entire document • S10_6.3_Member Educational Guidance, entire document • S10_6.3_CPG Coversheet, entire document • S10_6.4_Member Handbook, page 6 • S10_6.5_CPG Denial Notices, entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that decisions related to utilization management, member education, and coverage of services are consistent with established clinical practice guidelines. The Member Handbook and Utilization Management Policy detail that all care decisions—including prior authorization, service coverage, and educational resources—are based on evidence-based guidelines and current standards of care. Utilization management requests are reviewed by qualified clinicians using these resources to ensure appropriate and necessary services are provided, and all denials include written explanations referencing the applicable criteria.		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard X—Practice Guidelines							
Total	Met	=	6	X	1	=	6
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	**Total Score**		=	6

Total Score ÷ Total Applicable	=	**100%**

Standard XI—Health Information Systems

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCE maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to: a. Utilization; b. Claims; c. Grievances and appeals; and d. Disenrollments for other than loss of Medicaid eligibility. 42 CFR §438.242(a) 42 CFR §457.1233(d) MCO Contract: 2.19.1.2 PAHP Contract: 2.13.1.2 PIHP Contract: 14.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current completed Information Systems Capabilities Assessment Tool (ISCAT) through recent EQR activities (i.e., performance measure validation [PMV]) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by the State • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations **Evidence as Submitted by the MCE:** • S11_1.1_ITStandard Medicaid IT Provisions; pages 1-5 • S11_1.1_Medicaid Systems Flow: pages 1-2 • S11_1.1_Health information systems narrative; page 1	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• S11_1.2_Medicaid Systems Flow Mapping: pages 1-2 • S11_1.3_2024 LA NAV ISCAT; entire doc • S11_1.4_270_271 CompanionGuide, entire doc • S11_1.4_278 CompanionGuide, entire doc • S11_1.4_835 CompanionGuide; entire doc • S11_1.4_837 CompanionGuide; entire doc • S11_1.4_837d_CompanionGuide; entire doc • S11_1.4_Technical Manuals narrative, entire doc • S11_1.5_Cancel reasons; entire doc • S11_1.6_Disenrollment Code Narrative; entire doc	
MCE Description of Process: Humana employs a comprehensive health information system architecture that supports the collection, analysis, integration, and reporting of data essential for Medicaid managed care operations. The system includes multiple interconnected platforms and data repositories, such as the Enterprise Data Warehouse (EDW), Operational Data Store (ODS), and specialized modules for utilization management, claims processing, and grievance and appeals tracking. These components work together to ensure timely and accurate data capture across utilization, claims, grievances and appeals, and disenrollment processes, supporting both operational oversight and regulatory compliance. Data flows securely through standardized electronic transactions and is regularly monitored to ensure data integrity and support informed decision-making.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of a Health Information System		
2. The MCE collects data on member and provider characteristics as specified by the State and on all services furnished to members through an encounter data system or other method as may be specified by the State. 42 CFR §438.242(b)(2) 42 CFR §457.1233(d) MCO Contract: 2.18.1.1.5 PAHP Contract: 2.13.1.7.4 PIHP Contract: 16.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • S11_2.1_Provider Connectivity Claims Process Policy; pages 1-2 • S11_2.2_LA-ENC-006 Encounter Data Warehouse; page 1 • S11_2.2_EDW Claims & Encounter Data; entire doc • S11_2.2_Humana Data Reporting Environment, page 1 • S11_2.3_LA-ENC-006_Encounter Data Warehouse; entire doc • S11_2.3_LA-ENC-003_Encounter Submission, Resubs, Adjust & Voids; page 3	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana maintains a centralized Enterprise Data Warehouse (EDW) that integrates data from over 100 internal and external sources, including enrollment, claims, provider systems, and delegated network partners. This robust data infrastructure enables the collection of detailed information on member and provider characteristics, as well as comprehensive records of all services furnished to members, as required by the State.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE ensures that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. 42 CFR §438.242(b)(3) 42 CFR §457.1233(d) MCO Contract: 2.18.15.3.1; 2.18.15.10 PAHP Contract: 2.14.11.3 PIHP Contract: 16.6.2	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • S11_3.1_LA-ENC-003_Encounter Submission, Resubs, Adjust & Voids; entire doc • S11_3.1_LA.CLM.011 Louisiana Claims P&P; entire doc • S11_3.1_Systems Overview Narrative; entire doc • S11_3.1_Medicaid Systems Flow; entire doc • S11_3.2_Provider Manual; pages 9-11 • S11_3.3_ProviderConnectivity_Claims Process Policy; pages 1-2 • S11_3.5_LA.CLM.007 - Claims Payment Summary Monthly; entire doc • S11_3.5_Claims Payment Summary 103124; entire doc	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana maintains robust processes to ensure that all data received from providers is accurate, timely, and complete. Upon receipt, claims and encounter data are subjected to comprehensive validation checks, including verification of required data elements, logical consistency, and adherence to coding standards. Electronic submissions are required to follow standardized, HIPAA-compliant formats, and are transmitted via secure information exchanges. Regular quality reviews and system edits are conducted to identify and correct errors, supporting reliable data collection for Medicaid quality improvement and care coordination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE makes all collected data available to the State and upon request to CMS. 42 CFR § 438.242(b)(4) 42 CFR §457.1233(d) MCO Contract: 2.18.18.1.1 PAHP Contract: 2.13.9.1.2 PIHP Contract: 14.9.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • S11_4.1_LA.MAR.018 Reports & Requests for Information; page 1 • S11_4.1_ITStandard Medicaid IT Provisions; page 2	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana makes all collected data available to the State and upon request to CMS.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Claims Processing		
5. The MCE complies with section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines	☒ Met ☐ Not Met

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission). 42 CFR §438.242(b)(1) 42 CFR §457.1233(d) Affordable Care Act, Section 6504(a) Affordable Care Act, Section 1903(r)(1)(F) MCO Contract: 2.18.1.1 PAHP Contract: 2.14.2.1.3; 2.14.2.1.4 PIHP Contract: 15.2.2.7	• HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • S11_5.1_Provider Connectivity _Claims Process Policy; page 1-2	☐ NA
MCE Description of Process: Humana utilizes HIPAA-compliant electronic data interchange (EDI) systems and standardized X12 transactions to ensure the accurate submission and processing of claims. All electronic claims—covering institutional, professional, and dental services—are validated for completeness, accuracy, and adherence to both federal and state Medicaid requirements. Claims are screened through multiple automated edits, including state-specific business rules, before being securely transmitted and stored for reporting and analysis. These processes support compliance with section 6504(a) of the Affordable Care Act and the mechanized claims processing and retrieval system requirements of section 1903(r)(1)(F).		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Application Programming Interface		
6. The MCE implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCE. Information is made accessible to its current members or the members' personal representatives through the API as follows:	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing plan/results member educational materials, website materials, etc. • List of registered third-party applications	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one business day after a claim is processed; b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one business day after the data is received by the MCE; e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information. 42 CFR §438.242(b)(5) 42 CFR §431.60 42 CFR §457.1233(d) 45 CFR §170.213 MCO Contract: None PAHP Contract: None PIHP Contract: None	• HSAG will use the results from the API demonstration **Evidence as Submitted by the MCE:** • S11_6.1_Interoperability for Medicare & Medicaid: pages 1, 5, 7, 8 • S11_6.1_Policy Procedure & Workflow: entire doc • S11_6.2_API Doc and Website, entire doc • S11_6.3_3rdPartyVendors Narrative; page 1	
MCE Description of Process: Humana has implemented a suite of secure, standards-based APIs that provide members and their authorized representatives with timely access to health information, as outlined in federal regulations. Through these APIs, adjudicated claims data—including those related to appeals and cost-sharing - are made available no later than one business day after claims are processed. Encounter data from providers, including those paid by capitation and subcontractors, are accessible within one business day of receipt. Clinical data, such		

<table>
<tr><th colspan="3">Standard XI—Health Information Systems</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">as laboratory results, and information on covered outpatient drugs and formulary updates are also made available within one business day of receipt or effective date.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.
Recommendations: HSAG recommends that the MCE prioritize continued Application Programming Interface (API) development as it is essential to not only enabling valuable business functions but also meeting federal regulatory requirements.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td>7. The MCE maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which is conformant with the technical requirements at 45 CFR §431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at 45 CFR §431.60(d), and is accessible via a public-facing digital endpoint on the MCO's website.
42 CFR §438.242(b)(6)
42 CFR §431.70
42 CFR §438.10(h)(1-2)
42 CFR §457.1233(d)
MCO Contract: -2.13.2.3
PAHP Contract: 2.9.2.1.2.1; 2.9.8.3.1; 2.13.1.6
PIHP Contract: 5.9.2.30; 5.10.1; 6.1.20</td><td>HSAG Required Evidence:
• Policies, procedures, and workflows
• API documentation such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc.
• List of registered third-party applications
• HSAG will use the results from the web-based provider directory demonstration
Evidence as Submitted by the MCE:
• S11_7.1_InteroperabilityforMedicareandMedicaid; entire doc
• S11_7.2_Application Programming Interface Narrative; entire doc
• S11_7.3_LA No List of third party apps for Prov Dir; page 1

Additional Documentation:
• 11_1_Narrative</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana maintains a publicly accessible, standards-based Application Programming Interface (API) that provides up-to-date provider directory information. This API is available through a public-facing digital endpoint on Humana's website, allowing unrestricted access without the need for user authentication or authorization, in line with regulatory requirements. The provider</td></tr>
</table>

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
directory API delivers comprehensive and timely information on contracted providers, ensuring compliance with federal standards for accessibility and data accuracy. As required, Humana does not collect or report on third-party access to this API, since no security protocols or user registration are in place.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE ensure its public, searchable provider directory and Provider Directory API are updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).		
Required Actions: No action required.		
Member Encounter Data		
8. The MCE collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. 42 CFR §438.242(c)(1) 42 CFR §457.1233(d) MCO Contract: 2.18.1.1.1; 2.18.1.1.5 PAHP Contract: 2.14.2.1.3.1; 2.14.2.1.3.5 PIHP Contract: 15.2.2.3; 15.2.2.9	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • Two samples/screenshots of encounter data with rendering provider and item/service data fields (one sample must include encounter data from a sub-capitated source) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • S11_8.1_LA-ENC-003_Encounter Submission, Resubs, Adjust & Voids; page 1 • S11_8.1_Data Reporting Environment; page 1 • S11_8.1_EDW Claims & Encounter Data; entire doc • S11_8.3_HSAG Example 1; both tabs	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana's encounter data submission process ensures that all member encounters include detailed information identifying the provider who rendered each item or service. The Edifecs platform, used for encounter management, captures and transmits HIPAA-compliant 837 transactions containing essential provider identifiers alongside clinical and service details. This system supports the collection, retention, and reporting of comprehensive provider information for every encounter.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
9. The MCO submits member encounter data to the State at a frequency and level of detail, based on program administration, oversight, and program integrity needs. a. The member encounter data includes all State-specific requirements for encounter data submissions, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR §438.818. b. The member encounter data is submitted to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. MCO: a. *Submit complete and accurate encounter data at least monthly for all dates of service during the term of this Contract to LDH or the Fiscal Intermediary (FI) as directed by LDH* PAHP: a. *Submit complete and accurate encounter data at least monthly.* PIHP: a. *Submit complete and accurate encounter data at least weekly* 42 CFR §438.242(c)(2-4)	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent months/quarters of submission compliance (acceptance/rejection reports) • Two samples/screenshots of encounter data with allowed amount and paid amount fields (one sample must include encounter data from a sub-capitated source) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • S11_9.1_LA-ENC-003_Encounter Submission, Resubs, Adjust & Voids; page 1 • S11_9.3_LAMCD_ClaimEncounterLifeCycle; entire doc • S11_9.3_LAMCD_EncounterProcessFlowChart; entire doc • S11_9.4_HSAG Example 2; both tabs	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.818 42 CFR §457.1233(d) MCO Contract: 2.18.15.3.1; 2.18.15.4 PAHP Contract: 2.14.2.1.3.5; 2.14.11.10; 2.14.11.4 PIHP Contract: 14.3.3.1; 15.2.2.9; 15.6.2.1		
MCE Description of Process: Humana ensures timely and accurate submission of member encounter data to the State in accordance with program oversight and integrity requirements. The process includes the transmission of all State-specified data elements, such as allowed and paid amounts. Encounter data is submitted using standardized electronic formats. These submissions occur at least monthly and undergo multiple levels of editing and validation to align with State guidelines and support reliable data exchange with the State's systems.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XI—Health Information Systems							
Total	Met	=	9	X	1	=	9
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	**100%**

Standard XII—Quality Assessment and Performance Improvement

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCE establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members. 42 CFR §438.330(a)(1) 42 CFR §457.1240(b) MCO Contract: 2.16.2.1 PAHP Contract: 2.11.1.1.1 PIHP Contract: 12.1.1	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan **Evidence as Submitted by the MCE:** • S12.1.1_QAPI Committee Policy; Page 1 • S12.1.1_QAPI Charter; Page 2 • S12.1.1_QAPI Policy; Pages 1-2 • S12.1.2_QAPI Program Description; Pages 7-9, 19, 21-23,25,27-28, 31-32 • S12.1.3_QAPI Work Plan; Entire Document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana maintains a comprehensive Quality Assessment and Performance Improvement (QAPI) program to monitor, evaluate, and enhance the quality of health care services provided to its members. The QAPI program is structured to ensure continuous improvement by systematically assessing care and implementing targeted interventions across clinical, behavioral, and service domains. Oversight is provided through multidisciplinary committees that review outcomes, direct improvement initiatives, and ensure that members' needs are addressed through evidence-based practices and regular evaluation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of QAPI Programs		
2. The QAPI program includes mechanisms to assess both underutilization and overutilization of services. 42 CFR §438.330(b)(3) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Evidence demonstrating assessment of underutilization of services (e.g., committee meeting minutes, reports) • Evidence demonstrating assessment of overutilization of services (e.g., committee meeting minutes, reports) **Evidence as Submitted by the MCE:** • S12.2.1_QAPI Committee Policy; Page 3 • S12.2.1_QAPI Policy; Pages 1-2 • S12.2.2_QAPI Program Description; Pages 3, 7, 25, 33 • S12.2.3_QAPI Work Plan; Entire Document • S12.2.4_QAPI Program Evaluation; Pages 8, 22-25, 100-102, 182-185 • S12.2.5_QIC Summary; Entire Document • S12.2.6_QIC Summary; Entire Document • S12.2.6_QAPI Committee Minutes; Pages 53-55	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures its QAPI program actively monitors both underutilization and overutilization of services through systematic data review and regular committee oversight. The QAPI Committee evaluates service utilization patterns using various reporting tools and collaborates with specialized workgroups to identify trends, such as high utilization of behavioral health services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by the State in the quality strategy. 42 CFR §438.330(b)(4) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.8 PAHP Contract: 2.11.1.1.4 PIHP Contract: 12.1.1.3	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Definition of members with special health care needs • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs **Evidence as Submitted by the MCE:** • S12.3.1_CM Program Description; Pages 5, 16-17, 20 • S12.3.1_QAPI Committee Policy; Page 3 • S12.3.1_QAPI Policy; Page 1-2 • S12.3.2_QAPI Program Description; Page 3, 24 • S12.3.3_QAPI Work Plan, Entire Document • S12.3.4_QAPI Program Evaluation; Pages 63-68	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
	• S12.3.5_Executive Summary; Page 1 • S12.3.6_Health Needs Assessment; Entire Document • S12.3.6_Prenatal Maternity Assessment; Entire Document • S12.3.6_Postpartum Maternity Assessment; Entire Document • S12.3.6_Peds Comprehensive Assessment; Entire Document • S12.3.6_Adult Comprehensive Assessment; Entire Document • S12.3.7_CM Program Description; Pages 5, 16-17, 20 • S12.3.7_CM Program Referral Tool, Page 8 • S12.3.8_Q1 24 Executive Summary; Entire Document • S12.3.8_Q2 24 Executive Summary; Pages 1-2 • S12.3.8_Q3 24 Executive Summary; Pages 1-2 • S12.3.8_Q4 24 Executive Summary; Pages 1-2	
MCE Description of Process: Humana ensures that members with special health care needs are identified through comprehensive claims-based reporting and multiple referral sources. Upon identification, these members receive a thorough assessment within defined timeframes, allowing for the development of individualized, person-centered plans of care. The QAPI program provides oversight by monitoring assessment completion rates, plan of care development, and member engagement, with ongoing evaluation and quality improvement initiatives guided by multidisciplinary committees. Regular audits and continuous communication with state agencies further ensure that the care provided to members with special health care needs is both appropriate and of high quality, in alignment with state-defined strategies.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
4. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports (LTSS), including: a. Assessment of care between care settings; and b. Comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b) MCO Contract: NA PAHP Contract: None PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Medical record audit tools and results **Evidence as Submitted by the MCE:** •	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: We do not cover LTSS in Louisiana.		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Performance Measurement		
5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually: a. Measures and reports to the State on its performance, using the standard measures required by the State; b. Submits to the State data, specified by the State, which enables the State to calculate the MCO's performance using the standard measures identified by the State; or	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Performance measures reports	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
c. Performs a combination of the activities described in subelements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.4; 2.16.1.5 PAHP Contract: 2.11.1.1.2.3 PIHP Contract: 12.4.3.1	• Evidence of submission of performance measurement reports to the State **Evidence as Submitted by the MCE:** • S12.5.1_QAPI Committee Policy; Page 3 • S12.5.2_QAPI Program Description; Page 7 • S12.5.3_QAPI Work Plan; Entire Document • S12.5.4_QAPI Program Evaluation; Entire Document • S12.5.5_Race Ethnicity Sex Geography Stratification Template; Entire Document • S12.5.5_228 16306 210; Entire Document • S12.5.5_Audit Statement; Entire Document • S12.5.6_Audit Statement; Entire Document • S12.5.6_228 16306 210; Entire Document • S12.5.6_Race Ethnicity Sex Geography Stratification Template; Entire Document • S12.5.6_Report Upload; Entire Document	
MCE Description of Process: Humana's QAPI program systematically collects, analyzes, and reports performance measurement data in alignment with state requirements. The program tracks a comprehensive set of quality indicators and submits annual reports to the State, utilizing standardized measures specified by regulatory authorities. Data collection and reporting processes are designed to ensure accuracy and consistency, supporting both internal quality improvement and external oversight. Humana also provides the State with all required datasets, enabling independent calculation and verification of the plan's performance using the designated metrics.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
Performance Improvement Projects		
6. The QAPI program includes performance improvement projects (PIPs). a. The MCE conducts PIPs that focus on both clinical and nonclinical areas. MCO: a. *The MCO shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.* PIHP: a. *The PIHP shall perform a minimum of one LDH approved PIP.* 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b) MCO Contract: 2.16.11.1; 2.16.11.2 PAHP Contract: 2.11.3.1 PIHP Contract: 12.5.1; 12.5.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • List of all active PIPs, including which PIPs are considered clinical and non-clinical • Documentation for all active PIPs **Evidence as Submitted by the MCE:** • S12.6.1_QAPI Committee Policy; Page 3 • S12.6.1_QAPI Policy; Page 1 • S12.6.2_QAPI Program Description; Page 27 • S12.6.3_QAPI Work Plan; row 20 • S12.6.4_QAPI Program Evaluation; pages 89-97 • S12.6.5_QAPI Program Description; page 27 • S12.6.6_Performance Improvement Projects; pages 1-2	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana's QAPI program implements Performance Improvement Projects (PIPs) that address both clinical and nonclinical aspects of care. These projects are developed through a structured process that includes the identification of priority topics, establishment of measurable goals, and implementation of targeted interventions to improve health outcomes and member satisfaction. The PIPs are guided by continuous data collection and analysis, stakeholder input, and evidence-based practices, ensuring that both clinical care (such as preventive health and chronic condition management) and nonclinical services (such as access, satisfaction, and cultural competency) are addressed. Progress and outcomes of these projects are regularly reviewed by the QAPI Committee and reported to appropriate oversight bodies for evaluation and further action.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements: a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) 42 CFR §457.1240(b) MCO Contract: 2.16.11.5 PAHP Contract: 2.11.3.2 PIHP Contract: 12.5.3	**HSAG Required Evidence:** • QAPI program description • QAPI program work plan • QAPI program evaluation • Policies and procedures • Documentation for all active PIPs **Evidence as Submitted by the MCE:** • S12.7.1_QAPI Program Description; pages 17, 27 • S12.7.2_QAPI Work Plan; entire doc • S12.7.3_QAPI Program Evaluation; pages 89-97 • S12.7.4_Performance Improvement Projects; pages 2-3 • S12.7.5_QAPI PIP Report December 2024; entire doc • S12.7.5_QAPI PIP Report June 2024; entire doc	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana's PIPs are structured to drive measurable and lasting enhancements in health outcomes and member satisfaction. Each PIP begins with the selection of objective quality indicators, such as rates for cervical cancer screening or behavioral health transitions in care, which are regularly measured and analyzed. Targeted interventions, including provider training, member outreach, and community partnerships, are implemented to address identified gaps in access and quality of care. The effectiveness of these interventions is continually evaluated using state-required performance measures, and findings are used to refine strategies and initiate further activities to maintain or build upon improvements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
8. The MCE reports the status and results of each PIP to the State as requested, but not less than once per year. 42 CFR §438.330(d)(3) 42 CFR §457.1240(b) MCO Contract: 2.16.11.6 PAHP Contract: 2.11.3.3 PIHP Contract: 12.5.4.4	**HSAG Required Evidence:** • Policies and procedures • Evidence of annual submission of all PIPs to the State **Evidence as Submitted by the MCE:** • S12.8.1_Performance Improvement Projects; page 3 • S12.8.1_QA and PIP Description and Work Plan; page 2 • S12.8.2_Evidence of PIPs Submission 2; entire doc • S12.8.2.Evidence of PIPs Submission 1; entire doc	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana maintains a structured process for reporting the status and results of each PIP to the Louisiana Department of Health at least annually, or more frequently if requested. The process involves systematic collection and analysis of project data, including outcomes and progress toward established goals.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Critical Incidents		
9. The QAPI program includes participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h). 42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.730(a)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Three examples of critical incident reports • Committee meeting minutes • Provider remediation plan template(s)	☐ Met ☐ Not Met ☒ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1240(b) MCO Contract: 2.16.19 PAHP Contract: None PIHP Contract: 12.4.2.2	**Evidence as Submitted by the MCE:** • S12.9.1_Adverse Incident Reporting; entire doc • S12.9.2_QAPI Program Description; pages 26, 35 • S12.9.3_QAPI Work Plan; row 25 • S12.9.4_QAPI Program Evaluation; pages 42-44 • S12.9.5_fax-2024-12-08-163247_DR_(Adverse_Incident_3); entire doc • S12.9.5_fax-2024-11-11-144935_(Adverse_Incident_2); entire doc • S12.9.5_fax-2024-12-27-132318_Adverse_Incident (1); entire doc • S12.9.6_QAPI Minutes Fully Executed_12.19.24; pages 27-29 • S12.9.7_A CAP Notice of Deficiencies; entire doc	
MCE Description of Process: Humana's QAPI program actively collaborates with State efforts to prevent, identify, and address critical incidents that could impact the health and welfare of its members. The program maintains clear procedures for adverse incident reporting, including timely submission and investigation of events such as abuse, neglect, exploitation, or unexpected deaths. All incidents are promptly reviewed and appropriate remedial actions are implemented to protect members from further harm, in alignment with state and federal guidelines for home and community-based services. Regular audits, staff training, and coordination with protective agencies help ensure continuous improvement in safeguarding member well-being.		
HSAG Findings: Home and Community-Based Services waiver responsibilities are managed by the State through the fee-for-service (FFS) program and not through the MCEs; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
QAPI Program Reviews, Analysis, and Evaluation		
10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. MCO: a. *The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.* 42 CFR §438.330(e) 42 CFR §457.1240(b) MCO Contract: 2.16.6.2; 2.16.3.1; 2.16.7.1.2; 2.16.7.1.3 PAHP Contract: 2.11.2.3.1.2; 2.11.2.4.1.3 PIHP Contract: 12.2.3.4	**HSAG Required Evidence:** • Committee meeting minutes (with discussion of QAPI evaluation) **Evidence as Submitted by the MCE:** • S12.10_QAPI Minutes 3.27.24, pages 43-45	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana utilizes a structured process to evaluate the impact and effectiveness of its QAPI Program. The annual evaluation reviews required performance measures, the outcomes and trends of each PIP. Data are analyzed and reported to the QAPI Committee and governing body, which maintains oversight of the program and is responsible for reviewing findings and guiding ongoing improvements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
11. QAPI Committee Requirements: MCO: a. *The MCO forms a QAPI Committee that at a minimum includes:* i. *The MCO's Medical Director who must serve as either the chairman or co-chairman;* ii. *The MCO's Behavioral Health Director;* iii. *Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;* iv. *Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and* v. *An Enrollee representative(s) and/or advocate(s).* PAHP: a. *The PAHP shall form a QAPI Committee that shall, at a minimum include:* i. *The Dental Director who must serve as either the chairman or co-chairman;* ii. *Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and* iii. *The PAHP shall include an enrollee advocate representative on the QAPI Committee.* PIHP: a. *The PIHP shall form a QAPI committee that shall, at a minimum include:*	**HSAG Required Evidence:** • QAPI committee meeting minutes **Evidence as Submitted by the MCE:** • S12.11_QAPI_Minutes_3.27.24; entire doc • S12.11_QAPI_Minutes_6.26.24; entire doc • S12.11_QAPI Committee Minutes Q3 9.25.24; entire doc • S12.11_QAPI Minutes_12.19.24; entire doc	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard XII—Quality Assessment and Performance Improvement</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>i. The PIHP's Medical Director, who must serve as the chair or co-chair and
ii. Appropriate PIHP staff representing the various departments of the PIHP organization including but not limited to grievance and appeal staff and corporate compliance administrator responsible for fraud, waste and abuse activities.
MCO Contract: 2.16.4
PAHP Contract: 2.11.2
PIHP Contract: 12.2.1</td><td></td><td></td></tr>
<tr><td colspan="3">MCE Description of Process: Humana has established a QAPI Committee that meets all required membership and involvement criteria. The Committee is co-chaired by the plan's Medical Director and Behavioral Health Medical Director, ensuring clinical leadership and oversight. Membership includes substantial participation from both medical and behavioral health providers who serve enrollees, as well as representation from key organizational departments such as compliance, quality improvement, case management, pharmacy, provider relations, and credentialing. The Committee also incorporates enrollee representatives or advocates, ensuring that member perspectives are included in quality discussions and decision-making. This multidisciplinary structure supports comprehensive oversight and engagement in the QAPI program.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td>12. QAPI Committee Responsibilities:
MCO:
a. The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:
i. Direct and review quality management/quality improvement (QM/QI) activities and the QAPI Program overall;</td><td>HSAG Required Evidence:
• Policies and procedures
• QAPI committee meeting minutes
• Evidence of submission to the State
• Evidence of working with other Contractor staff and Subcontractors
• Evidence of updates to the Provider Manual
• Evidence of provider network performance reviews</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
</table>

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Requirement	**Supporting Documentation**	**Score**
ii. *Ensure that QAPI activities take place throughout the MCO's organization and ensure that providers are involved in the QAPI Program;* iii. *Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;* iv. *Create and direct task forces/committees to identify, review, and address areas of concern in the provision of health care services to Enrollees, including instituting needed action and ensuring that appropriate follow-up occurs;* v. *Designate evaluation and study design procedures;* vi. *Review provider network performance, including individual primary care provider (PCP), specialized behavioral health provider, and practice quality performance measure profiling to identify and address patterns;* vii. *Report findings to appropriate executive authority, staff, and departments within the MCO's organization;* viii. *Direct and analyze periodic reviews of Enrollees' service utilization patterns;* ix. *Maintain written minutes of all committee and sub-committee meetings and submit meeting minutes to LDH. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during EQRO reviews and during NCQA accreditation reviews;*	• Evidence of provider quality performance measure profiling • Evidence of periodic reviews of members' service utilization patterns **Evidence as Submitted by the MCE:** • S12.12.1_QAPI Committee Policy; Entire Document • S12.12.2_QAPI Minutes 03 24; Entire Document • S12.12.2_QAPI Minutes 06 24; Entire Document • S12.12.2_QAPI Minutes 09 24; Entire Document • S12.12.2_QAPI Minutes 12 24; Entire Document • S12.12.3_Evidence of Submission; Entire Document • S12.12.4_Q1 Subcontractor Oversight; Entire Document • S12.12.4_Q2 Subcontractor Oversight; Entire Document • S12.12.4_Q3 Subcontractor Oversight; Entire Document • S12.12.4_Q4 Subcontractor Oversight; Entire Document • S12.12.5_Provider Manual; Entire Document • S12.12.6_2023 Provider Network Monitoring; Entire Document • S12.12.6_Q1 24 Provider Network Monitoring; Entire Document	

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Requirement	**Supporting Documentation**	**Score**
x. *Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;* xi. *Ensure that the QAPI Committee chair, and/or the appropriate designee, participates in LDH's Quality Committee meetings and other quality related meetings as required;* xii. *Work with other Contractor staff and Subcontractors to establish policies and procedures to address specific quality concerns as required by this section of this Contract; and* xiii. *Update provider manuals and other relevant clinical content on a periodic basis as often as determined necessary by the committee chairperson.* PAHP: a. *The QAPI Committee shall:* i. *Meet on a quarterly basis;* ii. *Direct and review quality improvement (QI) activities;* iii. *Ensure that QAPI activities are implemented throughout the PAHP;* iv. *Review and suggest new and/or improved QI activities;* v. *Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;* vi. *Designate evaluation and study design procedures;*	• S12.12.6_Q2 24_Provider Network Monitoring; Entire Document • S12.12.6_2023_Quality Monitoring; Entire Document • S12.12.6_Q1 24 Quality Monitoring; Entire Document • S12.12.6_Q2 24 Quality Monitoring; Entire Document • S12.12.6_Q3 24 Quality Monitoring; Entire Document • S12.12.6_2023 Fidelity Monitoring; Entire Document • S12.12.6_Timely Access Summary; Entire Document • S12.12.6_2024_Network Adequacy Summary; Entire Document • S12.12.6_ June Provider Advisory Council; Entire Document • S12.12.6_ December Provider Advisory Council; Entire Document • S12.12.7_Provider Performance Report; Entire Document • S12.12.8_Q1 24 Executive Summary; Pages 1-4 • S12.12.8_Q2 24 Executive Summary; Pages 1-4 • S12.12.8_Q3 24 Executive Summary; Pages 1-5 • S12.12.8_Q4 24 Executive Summary; Pages 1, 3, 5	

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vii. *Conduct individual primary dental provider (PDP) and group practice quality performance measure profiling;* viii. *Report findings to appropriate executive authority, staff, and departments within the PAHP;* ix. *Direct and analyze periodic reviews of enrollees' service utilization patterns;* x. *Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and* xi. *Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.* PIHP: a. *QAPI committee responsibilities shall include:* i. *Directing and reviewing QI activities;* ii. *Ensuring that QAPI activities take place throughout the organization;* iii. *Suggesting new and/or improved QI activities;* iv. *Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;* v. *Conducting provider quality performance measure profiling;* vi. *Reporting findings to appropriate executive authority, staff, and departments within the PIHP;* vii. *Directing and analyzing periodic reviews of members' service utilization patterns; and*		

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Requirement	**Supporting Documentation**	**Score**
viii. *Maintaining minutes of all committee and sub-committee meetings and submitting meeting minutes, agendas, and referenced materials to LDH within five (5) business days following the meeting. The PIHP shall submit draft meeting minutes within five (5) business days following the meeting, if the final meeting minutes are not approved by the QAPI committee within five (5) business days following the meeting.* MCO Contract: 2.16.5 PAHP Contract: 2.11.2.2 PIHP Contract: 12.2.2		
MCE Description of Process: The QAPI Committee at Humana Healthy Horizons in Louisiana convenes at least quarterly to oversee and direct all quality management and improvement activities across the organization. Its responsibilities include evaluating and guiding the overall QAPI program, ensuring provider involvement, reviewing the outcomes of quality initiatives, and recommending policy enhancements or new activities. The committee is tasked with analyzing service utilization patterns, provider network performance, and identifying areas needing improvement, often through the creation of targeted task forces. Findings and recommendations are regularly communicated to executive leadership and relevant departments, and comprehensive meeting minutes are maintained and submitted to the appropriate authorities. The committee also ensures compliance with state requirements by reporting annually on the effectiveness of the QAPI program, participating in state-led quality meetings, and updating provider manuals and clinical content as necessary.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
13. QAPI Plan Requirements: MCO: a. *The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.*	**HSAG Required Evidence:** • QAPI Plan • Evidence of submission to the State **Evidence as Submitted by the MCE:** • S12.13.1_QAPI Work Plan; Entire Document	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
b. *The QAPI Plan shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions.* c. *The QAPI Plan, at a minimum, shall:* i. *Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;* ii. *Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;* iii. *Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;* iv. *Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;* v. *Be exclusive to the Louisiana Medicaid Program and shall not contain documentation from other State Medicaid programs or product lines operated by the Contractor; and* vi. *Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects Network Providers' adherence to clinical practice guidelines as appropriate.* PAHP: a. *The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction.* b. *The QAPI plan shall be submitted to LDH annually, and prior to revisions.*	• S12.13.1_QAPI Program Description; Entire Document • S12.13.2_QAPI Program Description; Entire Document • S12.13.2_QAPI Work Plan; Entire Document	

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Requirement	**Supporting Documentation**	**Score**
c. *The QAPI plan, at a minimum, shall:* i. *Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;* ii. *Include processes to evaluate the impact and effectiveness of the QAPI Program;* iii. *Include a description of the PAHP staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and* iv. *Describe the role of providers in giving input to the QAPI Program.* PIHP: a. *The QAPI committee shall develop and implement a written QAPI program description and work plan, which must be submitted to LDH within thirty (30) days of Division of Administration, Office of State Procurement (DOA/OSP) approval of the signed Contract and annually thereafter. The combined QAPI program description and work plan shall not exceed 30 pages unless otherwise approved by Office of Behavioral Health, Louisiana Department of Health (OBH).* b. *The QAPI program description at a minimum, shall:* i. *Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.* ii. *Include the methodology utilized for collecting data and describe the methods for ensuring data*		

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Requirement	**Supporting Documentation**	**Score**
collected and reported to LDH is valid and accurate. iii. *Specify the remediation actions that will be implemented when system performance is less than the required threshold.* iv. *Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention's effectiveness.* v. *Describe how the Contractor will obtain feedback from providers and members.* vi. *Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.* vii. *Be exclusive to the Coordinated System of Care (CSoC) Program and shall not contain documentation from other state Medicaid programs or product lines operated by the Contractor.* c. *The QAPI work plan at a minimum shall:* *Include objectives for the Contract year, inclusive of associated action steps and timelines.* i. *Include metrics and associated benchmarks for the wraparound agency scorecard.* ii. *Include a fidelity monitoring plan that includes utilization of a standardized fidelity monitoring tool to ensure the core elements of the wraparound*		

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facilitation are maintained, in accordance to the standards of practice established by the National Wraparound Initiative (NWI). The Contractor must conduct fidelity monitoring on an annual basis to ensure that the wraparound agencies (WAAs) adhere to evidence-informed practices. The fidelity plan at a minimum shall include the fidelity criteria for the sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. iii. *Include a plan to evaluate ongoing implementation of high-fidelity Wraparound in accordance with National Wraparound Initiative (NWI) standards inclusive of best practice indicators approved by OBH. The plan shall include a formalized monitoring review process of wraparound facilitator's (WF) demonstration of established wraparound competencies on a quarterly basis.* MCO Contract: 2.16.6 PAHP Contract: 2.11.2.3 PIHP Contract: 12.2.3		
MCE Description of Process: Humana's QAPI Committee is responsible for developing and implementing a comprehensive written QAPI Plan that aligns with strategic guidance from the governing body. This plan is submitted to the Louisiana Department of Health (LDH) during readiness review, annually thereafter, and prior to any revisions, ensuring transparency and accountability. The QAPI Plan outlines a coordinated approach for quality improvement, detailing planning, decision-making, interventions, and assessment of results, as well as the metrics used to evaluate program effectiveness. The document provides a thorough description of dedicated QAPI staff, their training, organizational structure, and responsibilities, and incorporates input from network providers and enrollees. The plan is tailored exclusively to the Louisiana Medicaid program and specifies robust methods for ensuring the validity and accuracy of data reported to LDH, including adherence to clinical practice guidelines by network providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Results for Standard XII—Quality Assessment and Performance Improvement							
Total	Met	=	11	X	1	=	11
	Not Met	=	0	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	11	**Total Score**		=	11

Total Score ÷ Total Applicable	=	100%

Standard XIII—Grievance and Appeal Systems

<table>
<tr><th colspan="3">Standard XIII—Grievance and Appeal Systems</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><th colspan="3">Grievance System General Requirements</th></tr>
<tr><td>1. The MCE defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision.
42 CFR §438.228
42 CFR §438.400(b)
42 CFR §457.1260(a)(2)(ii)
MCO Contract: Part 1: Glossary and Acronyms
PAHP Contract: 7.1
PIHP Contract: 11.2.3</td><td>HSAG Required Evidence:
• Policies and procedures
• Member materials, such as the member handbook
Evidence as Submitted by the MCE:
• S13_1.1_G+A Policy; page 8
• S13_1.2_Member Handbook; page 23, paragraph 2</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana has established a structured process to address member grievances, which are defined as expressions of dissatisfaction about issues unrelated to adverse benefit determinations. Humana reviews and resolves these grievances in a thorough and timely manner, ensuring that all concerns are appropriately addressed and that members' rights are respected throughout the process.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td>2. A member may file a grievance with the MCE at any time.
a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.</td><td>HSAG Required Evidence:
• Policies and procedures
• Member materials, such as the member handbook
• Member consent form template</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
</table>

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.3.6.1	• HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13_2.1_AOR; page 5 • S13_2.1_Grievance First Level; page 2 • S13_1.2_Member Handbook; page 23, paragraph 3 • S13_2.3_AOR Form; entire document • S13_2.3_AOR Letter Template; entire document • S13_2.3_Aux Aids Notice; entire document • S13_2.3_Non-Discrimination Notice; entire document	
MCE Description of Process: Humana provides members the opportunity to file a grievance at any time regarding their care or service experience. If a member wishes, they may authorize a provider or representative to file a grievance on their behalf by completing the necessary Appointment of Representative form or submitting other legal documentation, such as a power of attorney. This process ensures that grievances can be submitted either directly by the member or through a chosen representative with written consent.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The member may file a grievance either orally or in writing. 42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1) MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.1.8; 11.3.6.1; 11.3.6.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 2	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• S13_2.1_Grievance First Level; page 2 • S13_1.2_Member Handbook; page 23	
MCE Description of Process: Humana allows members to submit grievances either orally or in writing, ensuring accessibility and flexibility in the process. Upon receipt of a grievance, Humana promptly provides written acknowledgment within the specified timeframe. The grievance is reviewed and resolved by qualified personnel, and the member is notified of the outcome in writing.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Handling of Grievances		
4. The MCE acknowledges receipt of each grievance. MCO and PAHP: a. *The MCO's/PAHP's process for handling enrollee grievances shall include acknowledgement in writing within five (5) business days of receipt of each grievance.* PIHP: a. *Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.* 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1	**HSAG Required Evidence:** • Policies and procedures • Grievance acknowledgment notice template • Tracking and reporting mechanisms • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 2 • S13_2.1_Grievance First Level; page 3 • S13_4.2_Grievance Ack Letter; entire document • S13_4.3_Grievance Ack Report; entire document	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana promptly acknowledges receipt of each grievance by sending a formal written letter to the member or authorized representative. This acknowledgment is provided within five business days of receiving the grievance, ensuring timely communication. The letter confirms the grievance has been received, provides a reference number, and outlines the next steps in the review process. Members are informed of their ability to submit additional information and are provided with contact details for further assistance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE ensures that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3; 11.4.1.1.3.3	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of grievance staff members, including credentials • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 2 • S13_2.1_Grievance First Level; page 4 • S13_5.2_G+A Org Chart; entire document	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures that grievance decisions are made by individuals who were not involved in any prior review or decision-making for the case, and are not subordinates of those who were. For grievances involving clinical issues or expedited resolution denials, decision-makers possess the appropriate clinical expertise relevant to the member's specific condition. This structure supports impartiality and clinical appropriateness in the grievance process, as outlined in internal organizational procedures.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Timely Resolution and Notification of Grievances		
6. The MCE resolves each grievance, and provides notice, as expeditiously as the member's health condition requires, within State-established timeframes that do not exceed the timeframes specified in 42 CFR §438.408. MCO and PAHP Standard Grievances a. *The MCO/PAHP shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) Calendar Days from the date the MCO/PAHP receives the grievance.* PIHP Standard Grievances a. *For standard resolution of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the Contractor receives the grievance.* 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12) MCO Contract: 2.15.2.3 PAHP Contract: 2.10.2.3 PIHP Contract: 11.4.8.1.1	**HSAG Required Evidence:** • Policies and procedures • Grievance resolution notice template or oral notification script • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13_2.1_Grievance First Level; page 3 • S13_6.1_Grievance Resolution Metric; entire document • S13_6.2_Grievance Res Letter; entire document • S13_6.3_Compliance Report; entire document	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard XIII—Grievance and Appeal Systems</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCE Description of Process: Humana reviews each grievance thoroughly and issues a written notice to the member regarding the outcome within the required timeframes. The resolution letter acknowledges receipt of the grievance, summarizes the concerns, and provides a detailed explanation of the decision and any actions taken. The notice is delivered as quickly as needed for the member’s health and always within the ninety-day limit established by regulation.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if:
a. The member requests the extension; or
b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.
42 CFR §438.228
42 CFR §438.408(c)(1)
42 CFR §457.1260(e)(1)
MCO Contract: 2.15.2.4
PAHP Contract: 2.10.2.4
PIHP Contract: 11.4.8.4</td><td>HSAG Required Evidence:
• Policies and procedures
• Tracking and reporting mechanisms
• Two examples of a grievance with extensions with LDH approval
• HSAG will use the Universe File to evaluate timeliness
• HSAG will also use the results of the Grievances File Review</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S13_1.1_G+A Policy; page 3
• S13_2.1_Grievance First Level; page 4
• S13_7.2_Ext Metric Tracking; entire document
• S13_7.3_Examples Narrative; entire document</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana permits an extension of up to 14 calendar days for resolving grievances when additional time is necessary. An extension may be granted if requested by the member or if it is demonstrated that more information is needed and the delay serves the member’s best interest. No grievance extensions were taken in 2024.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
</table>

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
8. If the MCE extends the grievance resolution timeframe not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.2.5 PAHP Contract: 2.10.2.5 PIHP Contract: 11.4.8.4.2	**HSAG Required Evidence:** • Policies and procedures • Grievance extension template letter • Two examples of grievances with extensions with oral and written notice • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 3 • S13_2.1_Grievance First Level; page 4 • S13_8.2_Ext Letter Template Narrative; entire document • S13_8.3_Grievance Ext Examples Narrative; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: When Humana extends the grievance resolution timeframe for reasons other than the member's request, it follows a clear notification process. The member is first given prompt oral notice of the delay to ensure timely communication and transparency. Within two calendar days, Humana also provides a written notice explaining the reason for the extension and informing the members of their right to file a grievance if they disagree with the decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Appeals General Requirements		
9. The MCE defines an appeal as a review by the MCE of an ABD. 42 CFR §438.228 42 CFR §438.400(b)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1260(a)(2)(ii) MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.2	**Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 7 • S13_9.1_Expedited Appeal; page 2 • S13_9.1_Standard Appeal; page 2 • S13_1.2_Member Handbook; page 23 • S13_9.3_Provider Manual; page 56 • S13_9.3_Provider Manual Narrative; entire document	
MCE Description of Process: Humana follows a formal process for reviewing member appeals, which are defined as requests for review of an adverse benefit determination (ABD).		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. The MCE has only one level of appeal for members. 42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1) MCO Contract: None PAHP Contract: None PIHP Contract: 11.1.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S13_10.1_Dual Demo G+A; page 1 • S13_10.2_Member Handbook; page 24 • S13_10.3_Provider Manual; page 56 • S13_9.3_Provider Manual Narrative; entire document **Additional Documentation:** • 2025 Provider Manual	☐ Met ☐ Not Met ☒ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: When a member wishes to appeal an adverse benefit determination, they are provided with clear instructions and support throughout the single-level appeal process. The procedure is designed to ensure members receive timely decisions and are informed of their rights.		
HSAG Findings: During the compliance review, HSAG identified that LDH's contract with the MCEs required the MCEs to maintain an informal reconsideration/peer-to-peer process. HSAG has scored this element as not applicable since State requirements differ from federal requirements. HSAG has communicated this information to LDH.		
Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		
11. The MCE establishes and maintains an expedited review process for appeals, when the MCE determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f) MCO Contract: 2.15.3.4.1; 2.15.4.11 PAHP Contract: 2.10.4.1; 2.10.6.12 PIHP Contract: 11.4.9.1; 11.5.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 7 • S13_1.2_Member Handbook; page 25 • S13_10.3_Provider Manual; page 56 • S13_9.3_Provider Manual Narrative; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana has a process in place to ensure that expedited appeals are reviewed promptly when a delay could jeopardize a member's life, health, or functional abilities. If a provider requests an expedited review or supports a member's appeal, Humana guarantees that no punitive action is taken against the provider for doing so.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. Following receipt of a notification of an ABD by an MCE, the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal to the MCE. 42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1) MCO Contract: 2.15.3.1.1 PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.3.5.3	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 3 • S13_9.1_Expedited Appeal; page 2 • S13_9.1_Standard Appeal; page 2 • S13_12.2_Tracking Narrative; entire document • S13_1.2_Member Handbook; page 24 • S13_12.4_Denial Notice Letter Template • S13_10.3_Provider Manual; page 56 • S13_9.3_Provider Manual Narrative; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: After receiving a notification of an ABD, members have 60 calendar days from the date of the notice to request an appeal. Humana tracks the timeliness of appeal requests by documenting the date of the ABD notification and the date the appeal request is received, ensuring appeals are filed within the required timeframe. The process is designed to provide members with clear instructions and multiple methods for submitting appeals, such as by phone, mail, fax, or online.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
13. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. 42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) MCO Contract: 2.15.1.11; 2.15.3.1.1 PAHP Contract: 2.10.1.11; 2.10.3.1.1 PIHP Contract: 11.3.6.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 3 • S13_9.1_Expedited Appeal; page 2 • S13_9.1_Standard Appeal; page 2 • S13_1.2_Member Handbook; page 24 • S13_13.3_Appeal AOR Letter Template; entire document • S13_2.3_AOR Form; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana allows members to file an appeal either orally or in writing, ensuring accessibility and convenience for all members. If a provider or authorized representative wishes to request an appeal on behalf of a member, they must submit appropriate documentation, such as a completed Appointment of Representative form or other legal documents demonstrating their authority. Humana sends a formal notification to the requestor outlining these requirements and provides clear instructions for submitting the necessary paperwork.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Handling of Appeals		
14. If the MCE denies a request for expedited resolution of an appeal, it:	**HSAG Required Evidence:** • Policies and procedures • Denied expedited resolution letter template	☒ Met ☐ Not Met

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
a. Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2). b. Follows the requirements in 42 CFR §438.408(c)(2), including: i. Makes reasonable efforts to give the member prompt oral notice of the delay. ii. Within two calendar days, gives the member written notice of the reason for the decision to deny the expedited appeal resolution timeframe and informs the member of the right to file a grievance if the member disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2) 42 CFR §438.410(c) 42 CFR §457.1260(f) MCO Contract: 2.15.3.4.4; 2.15.3.4.5 PAHP Contract: 2.10.4.4; 2.10.4.5 PIHP Contract: 11.4.9.1.1.1; 11.4.9.1.1.2; 11.4.9.2	• HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 3-4 • S13_9.1_Expedited Appeal; page 4 • S13_14.2_Expedited Not Met Letter; entire document • S13_2.3_Aux Aids Notice; entire document • S13_2.3_Non-Discrimination Notice; entire document	☐ NA
MCE Description of Process: When a request for expedited resolution of an appeal does not meet the necessary criteria, Humana transitions the appeal to the standard resolution timeframe. The member is promptly informed by phone of this change and the reason for the decision. Within two calendar days, Humana sends a written notice explaining why the expedited process was denied and advising the member of their right to file a grievance if they disagree with the decision. The member is also informed of their ability to submit additional supporting information and to review their case file at no cost.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
15. The MCE acknowledges receipt of each appeal. MCO and PAHP: a. *The MCO/PAHP shall acknowledge each appeal in writing within five (5) business days of receipt of each appeal unless the enrollee requests an expedited resolution.* PIHP: a. *Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.* 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) MCO Contract: 2.15.3.1.3 PAHP Contract: 2.10.3.3 PIHP Contract: 11.4.1.1.1	**HSAG Required Evidence:** • Policies and procedures • Appeal acknowledgment template • Tracking and reporting mechanisms • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 3 • S13_9.1_Standard Appeal; page 3 • S13_15.2_Appeal Ack Letter • S13_15.3_Appeal Ack Tracking; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana promptly acknowledges the receipt of each appeal in writing, ensuring timely communication with the member or their representative. Upon receiving an appeal, a formal acknowledgment letter is sent within five business days, unless the request is for expedited resolution. This letter confirms receipt of the appeal, provides information on the review process, and outlines how to submit additional information or access the case file.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

<table>
<tr><th colspan="3">Standard XIII—Grievance and Appeal Systems</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td rowspan="2">16. The MCE ensures that the individuals who made decisions on appeals are individuals:
a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.
b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:
i. An appeal of a denial that is based on lack of medical necessity.
ii. An appeal that involves clinical issues.
c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD.
42 CFR §438.228
42 CFR §438.406(b)(2)
42 CFR §457.1260(d)
MCO Contract: 2.15.1.3
PAHP Contract: 2.10.1.3
PIHP Contract: 11.4.1.1.3</td><td>HSAG Required Evidence:
• Policies and procedures
• Organizational chart of appeal staff members, including credentials
• HSAG will also use the results of the Appeals File Review</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S13_1.1_G+A Policy; page 2
• S13_9.1_Expedited Appeal; page 4
• S13_9.1_Standard Appeal; page 4
• S13_16.2_NMR Reviewers; entire document
• S13_16.2_Appeal Organizational Chart; entire document</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana ensures that individuals responsible for making decisions on appeals are independent from those involved in any prior level of review or decision-making and are not subordinates of such individuals. For appeals related to medical necessity or involving clinical issues, Humana assigns decision-makers with appropriate clinical expertise relevant to the member’s condition or disease. The appeal reviewers carefully consider all information provided by the member or their representative, including any new or previously unconsidered evidence.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
</table>

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the MCE document staff member names and credentials for documentation of who made decisions on grievances and appeals.		
Required Actions: No action required.		
17. The MCE treats oral inquiries seeking to appeal an ABD as appeals. 42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d) MCO Contract: None PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.4.2.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 3-4 • S13_1.2_Member Handbook; page 24	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana recognizes oral inquiries from members seeking to appeal an ABD as official appeals and processes them accordingly. Upon receiving an oral appeal, Humana records the date of the request as the official receipt date and promptly initiates the appeal process. Members are notified in writing to confirm receipt of the appeal and are provided with information about the next steps in the process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
18. The MCE provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The MCE informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) MCO Contract: 2.15.3.1.4; 2.15.3.4.3 PAHP Contract: 2.10.3.1.3 PIHP Contract: 11.4.2.2	**Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 5 • S13_18.2_Appeal Ack Letter; entire document • S13_18.2_NABD Letter; entire document	
MCE Description of Process: Humana ensures that members are given a reasonable opportunity to present evidence, submit testimony, and make both legal and factual arguments in support of their appeal. Members are notified in writing of their ability to submit additional information, either in person or in writing, and are provided with clear instructions on how to do so. The notification also outlines the relevant timeframes and encourages timely submission of any supporting materials, ensuring the member has adequate time to participate in the process before a decision is made.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
19. The MCE provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the ABD. a. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c). MCO and PAHP: a. *Upon request, the MCO/PAHP shall provide the enrollee and his or her authorized representative the enrollee's record, including all medical records and*	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 2 • S13_18.2_Appeal Ack Letter; entire document • S13_18.2_NABD Letter; entire document	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
any other documents and records considered or relied upon by the MCO/PAHP regarding an appeal or state fair hearing, including the opportunity before and during the appeal or state fair hearing process for the enrollee or an authorized Representative to examine the record. The MCO/PAHP shall provide such records free of charge and within seven (7) calendar days of receipt of the request. 42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) MCO Contract: 2.15.1.6; 2.15.3.1.5 PAHP Contract: 2.10.1.6 PIHP Contract: 11.4.2.3	• S13_19.2_Disclosure Letter; entire document	
MCE Description of Process: Humana ensures that members and their authorized representatives have access to the complete case file related to their appeal, which includes medical records, documents, and any new or additional evidence considered during the appeals process. This information is provided free of charge and members are informed of their right to review their file at any time, as stated in the appeal acknowledgment and adverse benefit determination letters. Upon request, Humana sends the requested records within seven calendar days, ensuring the member or representative has sufficient time to review the information before an appeal decision is made.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Resolution and Notification of Appeals		
20. The MCE resolves standard appeals and sends notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the MCE receives the appeal. 42 CFR §438.228	**HSAG Required Evidence:** • Policies and procedures • Tracking documentation • HSAG will use the Universe File to evaluate timeliness	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2) MCO Contract: 2.15.3.3.1 PAHP Contract: 2.10.3.7 PIHP Contract: 11.4.8.2.1	• HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 3 • S13_9.1_Standard Appeal; page 3 • S13_20.2__Appeal Resolution Metric; entire document	
MCE Description of Process: Humana resolves standard appeals promptly, ensuring decisions are made as quickly as the member's health condition requires, and always within 30 calendar days of receiving the appeal. Upon reaching a determination, written notice is sent to the member or their authorized representative, as appropriate. This notification includes the resolution, the date of the decision, and pertinent information about the right to request a Medicaid Fair Hearing.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
21. The MCE resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the MCE receives the appeal. 42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.2 PAHP Contract: 2.10.4.2 PIHP Contract: 11.4.8.3.1	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 5 • S13_9.1_Expedited Appeal; page 3 • S13_21.2_Compliance Report; entire document	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana resolves expedited appeals as quickly as the member's health condition requires, but always within 72 hours of receiving the appeal request, regardless of whether it was submitted orally or in writing. Once a determination is made, the member is promptly notified by phone, followed by a written notice within two calendar days of the resolution. This written communication includes the decision, the date of the resolution, and information about further rights such as requesting a Medicaid Fair Hearing. The process ensures that all affected parties are kept informed in a timely manner.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
22. The MCE may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if: a. The member requests the extension; or b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.5.1 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Two examples of appeals with extended time frame with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 4 • S13_9.1_Standard Appeal; page 4 • S13_22.2_Appeal Ext Tracking; entire document • S13_22.3_Appeal Examples Narrative; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana Healthy Horizons in Louisiana follows established protocols that allow for the extension of appeal resolution timeframes by up to 14 calendar days under specific circumstances. An extension may be granted if it is requested by the member or		

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Requirement	**Supporting Documentation**	**Score**
if additional information is needed and the delay serves the member's best interests, as determined in coordination with the State agency. In 2024, there were no instances in which appeal extensions were taken, demonstrating adherence to standard timeframes for appeal resolutions.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
23. If the MCE extends the standard or expedited appeal resolution timeframes not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. c. Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2) MCO Contract: 2.15.3.5.2 PAHP Contract: 2.10.2.5; 2.10.2.5.3 PIHP Contract: 11.4.8.4.2	**HSAG Required Evidence:** • Policies and procedures • Two examples of appeals with extended time frame with oral and written notice • Appeal extension template letter • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 4 • S13_9.1_Standard Appeal; page 4 • S13_23.2_Appeals Ext Examples Narrative; entire document • S13_23.3_Appeal Ext Letter	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana follows a thorough process when extending appeal resolution timeframes without a member's request. When an extension is necessary, Humana promptly makes reasonable efforts to provide the member with oral notice of the delay. Within two calendar days, written notice is sent to the member explaining the reason for the extension and informing them of their right to file a grievance if they disagree with the decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
24. In the case that the MCE fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCE's appeals process. The member may initiate a State fair hearing (SFH). 42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3) MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.8.4.3.1	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Member materials, such as the member handbook • Appeal notice template for untimely appeal resolution • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 4 • S13_24.1_Medicaid Fair Hearing; page 2 • S13_24.2_MFH Tracking; entire document • S13_24.3_Appeal Resolution Letter; entire document • S13_24.3_Overturn Resolution Letter; entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: If Humana does not meet the required appeal notice and timing requirements, the member is considered to have exhausted the internal appeals process. In such cases, the member or their authorized representative may request a State fair hearing through the Louisiana Department of Health. Requests can be submitted in writing, orally, by fax, or online within 120 calendar days of the adverse appeal resolution notice.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
25. For all appeals, the MCE provides written notice of the appeal resolution that includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCE's ABD related to the appeal. MCO: a. *The MCO shall provide the enrollee with a written notice of appeal resolution using a template approved by LDH in writing.* b. *The MCO shall include on the notice a unique identifying number, corresponding to the number on the notice of ABD that gave rise to the appeal.* c. *For Appeals not resolved wholly in favor of the enrollees, the notice shall include all information required under 42 CFR 438.408, including, but not limited to, informing the enrollee of their right to seek a State Fair Hearing if the enrollee is not satisfied with the MCO's decision in response to an appeal, and the process for doing so.*	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 5 • S13_9.1_Expedited Appeal; page 6 • S13_9.1_Standard Appeal; page 5 • S13_24.3_Appeal Resolution Letter; entire document • S13_24.3_Overturn Resolution Letter; entire document **Additional Documentation:** • LDH Letter • Humana Catalog 4.19.23 • Email • Email 2 • Email 3	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PAHP: a. *The PAHP shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.* b. *The PAHP shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the appeal.* c. *The PAHP shall inform the enrollee of their right to seek a state fair hearing if the enrollee is not satisfied with the PAHP's decision in response to an appeal, and the process for doing so.* 42 CFR §438.228 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4) MCO Contract: 2.15.3.6 PAHP Contract: 2.10.5 PIHP Contract: 11.4.13		
MCE Description of Process: Humana provides members with a formal written notice for all appeal resolutions, detailing the outcome and the date the decision was made. If an appeal is not resolved entirely in the member's favor, the notice clearly informs the member of their right to request a State Fair Hearing and provides step-by-step instructions on how to do so. It also explains the process for requesting continued benefits during the hearing and notifies the member that they may be responsible for costs if the decision is upheld against them. Each notice contains a unique reference number linked to the original appeal.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
26. For notice of an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice. MCO and PAHP: a. *In the case of an expedited appeal denial, the MCO/PAHP shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two (2) calendar days of the disposition.* 42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.5 PAHP Contract: 2.10.4.5 PIHP Contract: 11.4.13.2	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 5 • S13_9.1_Expedited Appeal; page 5	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that, for expedited appeals, members are promptly informed of the resolution through a two-step notification process. When an expedited appeal is resolved, Humana makes reasonable efforts to provide oral notice to the member by the close of business on the day the decision is made. Following this, a written notice detailing the outcome of the appeal is sent to the member within two calendar days.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
State Fair Hearings and State External Review		
27. The member may request a SFH only after receiving notice that the MCE is upholding the ABD related to the appeal. a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member.	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5) Contract H.4.03 MCO Contract: 2.15.1.11; 2.15.4.1 PAHP Contract: 2.10.2.11; 2.10.6.1 PIHP Contract: 11.3.4.2; 11.4.14.2	**Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 5 • S13_24.3_Appeal Resolution Letter; entire document • S13_1.2_Member Handbook; page 26	
MCE Description of Process: Humana ensures that members are informed of their right to request a State Fair Hearing only after receiving written notice that their appeal has been upheld by the plan. This notice clearly outlines the steps for requesting a hearing and explains that, with the member's written consent, a provider or authorized representative may also submit a request on the member's behalf.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's policies and procedures did not include that with the written consent of the member, a provider or an authorized representative may request a State fair hearing (SFH) on behalf of the member.		
Required Actions: The MCE must revise its policies and procedures to include the requirement that with the written consent of the member, a provider or an authorized representative may request an SFH on behalf of the member.		
28. The member has *120 calendar days* from the date of the MCE's notice of appeal resolution to request an SFH. MCO: a. *An enrollee or other party to the appeal, who has completed the MCO's appeal procedure, may request a State Fair Hearing within one hundred twenty (120) Calendar Days after receiving a notice of appeal resolution indicating that the MCO is upholding, in whole or in part, the ABD, or after the MCO fails to adhere to the notice and timing requirements applicable to appeals.* PAHP: a. *An enrollee or authorized representative, who has completed the PAHP's appeal process, may request a*	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 5 • S13_24.1_Medicaid Fair Hearing; page 2 • S13_24.3_Appeal Resolution Letter; entire document	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
state fair hearing within one hundred twenty (120) calendar days after receiving a notice of appeal resolution indicating that the PAHP is upholding, in whole or in part, the adverse benefit determination, or after the PAHP fails to adhere to the notice and timing requirements applicable to appeals. PIHP: a. *The member may request a State Fair Hearing only after receiving notice that the PIHP is upholding the adverse benefit determination. The member may request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the PIHP's notice of resolution.* 42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5) MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.14.2	• S13_24.3_Overturn Resolution Letter; entire document • S13_1.2_Member Handbook; page 26	
MCE Description of Process: Humana informs members that they have 120 calendar days from the date of the appeal resolution notice to request a State Fair Hearing if their appeal is upheld in whole or in part, or if Humana does not meet appeal notice and timing requirements. This right is clearly outlined in the appeal resolution letter, which provides instructions for submitting a State Fair Hearing request, including contact information for the Louisiana Department of Health. Members are advised that they or their authorized representatives may file this request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

<table>
<tr><th colspan="3">Standard XIII—Grievance and Appeal Systems</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">Continuation of Benefits</td></tr>
<tr><td>29. The MCE continues the member’s benefits if all of the following occur:
a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).
b. The appeal involves the termination, suspension, or reduction of previously authorized services.
c. The services were ordered by an authorized provider.
d. The period covered by the original authorization has not expired.
e. The member timely files for continuation of benefits.

MCO/PAHP/PIHP:
a. Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.

Timely files means on or before the later of the following: within 10 calendar days of the MCE sending the notice of ABD, or the intended effective date of the MCE’s proposed ABD.

42 CFR §438.228
42 CFR §438.420(a-b)
MCO Contract: 2.15.3.2.1
PAHP Contract: 2.10.3.4
PIHP Contract: 11.6.2</td><td>HSAG Required Evidence:
• Policies and procedures
• ABD notice template
• Appeal resolution notice template
• HSAG will also use the results of the Appeals File Review

Evidence as Submitted by the MCE:
• S13_1.1_G+A Policy; page 6
• S13_29.2_Partial Denial Letter
• S13_24.3_Appeal Resolution Letter; entire document</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana maintains a process to ensure members can continue receiving their benefits when certain conditions are met. If a member requests an appeal within 60 days of the adverse benefit determination notice and the appeal concerns the reduction, suspension, or termination of services previously authorized by a qualified provider, benefits may continue as long as the original authorization</td></tr>
</table>

<table>
<tr><th colspan="3">Standard XIII—Grievance and Appeal Systems</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">period remains active and the member requests continued benefits in a timely manner. The request for continued services must be made within ten calendar days of the notice.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td>30. If, at the member’s request, the MCE continues or reinstates the member’s benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs:
a. The member withdraws the appeal or request for SFH.
b. The member fails to request a SFH and continuation of benefits within 10 calendar days after the MCE sends the notice of an adverse resolution to the member’s appeal.
c. A SFH office issues a hearing decision adverse to the member.
MCO and PAHP:
a. Appeals
i. The time period or service limits of a previously authorized service has been met.
42 CFR §438.228
42 CFR §438.420(c)
MCO Contract: 2.15.3.2.2; 2.15.4.8
PAHP Contract: 2.10.3.5; 2.10.6.9
PIHP Contract: 11.6.3</td><td>HSAG Required Evidence:
• Policies and procedures
• ABD notice template
• HSAG will also use the results of the Appeals File Review
Evidence as Submitted by the MCE:
• S13_1.1_G+A Policy; page 6
• S13_30.2_Denial Letter; pages 3 & 4
Additional Documentation:
• G & A Policy
• Narrative</td><td>☐ Met
☒ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana continues or reinstates a member’s benefits during the appeal or State Fair Hearing process if the member requests it, as outlined in the denial notice. These continued benefits remain in place until one of several events occurs: the member withdraws their appeal or hearing request, does not timely request a State Fair Hearing and continuation of benefits within ten calendar days of</td></tr>
</table>

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
the adverse appeal decision, or the hearing office issues a decision that is not in the member's favor. Additionally, benefits will end if the original authorization's time period or service limits are reached.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's Grievance and Appeals policy did not include the requirement for appeals of "the time period or service limits of a previously authorized service has been met."		
Required Actions: The MCE must update its Grievance and Appeals policy, and any other applicable documents to include the requirement for appeals of "the time period or service limits of a previously authorized service has been met."		
31. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCE's ABD, the MCE may, consistent with the state's usual policy on recoveries under 42 CFR §431.230(b) and as specified in the MCE's contract, recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420. 42 CFR §438.228 42 CFR §438.420(d) MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 6 • S13_31.2_Denial Letter • S13_24.3_Appeal Resolution Letter; entire document **Additional Documentation:** • G & A Policy • Narrative	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: If the outcome of the appeal or State Fair Hearing is not in the member's favor and upholds Humana's original adverse benefit determination, Humana may seek to recover the cost of any services that were continued during the appeal process. This action is taken in alignment with federal regulations, which allow for recovery when services were provided solely due to the requirement to continue		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
benefits while the appeal or hearing was pending. Members are informed of this possibility in their denial and appeal resolution notices, which explain that they may be financially responsible for these services if the decision is upheld.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The Grievance and Appeals policy did not include the requirement that if the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCE's ABD, the MCE may, consistent with the State's usual policy on recoveries under 42 CFR §431.230(b) and as specified in the MCE's contract, recover the cost of services furnished to the member while the appeal and SFH were pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420.		
Required Actions: The MCE must update its policies and procedures to include the requirement that if the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCE's ABD, the MCE may, consistent with the State's usual policy on recoveries under 42 CFR §431.230(b) and as specified in the MCE's contract, recover the cost of services furnished to the member while the appeal and SFH were pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420.		
32. If the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations. 42 CFR §438.228 42 CFR §438.424(b) MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 6 • S13_24.1_Medicaid Fair Hearing; page 5 • S13_32.2_Member Rights + Resp; entire document • S13_32.3_Contract Training; entire document **Additional Documentation:** • G & A Policy • Narrative	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: If a decision to deny authorization of services is reversed by either Humana or the State Fair Hearing officer, and the member received the services in question while the appeal was under review, Humana ensures that payment for those services is made in accordance with state policy and regulations. This process supports the member's right to receive timely and appropriate care without financial penalty when an appeal results in a favorable outcome.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The Grievance and Appeals policy did not include the requirement that if the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations.		
Required Actions: The MCE must update its Grievance and Appeals policy to include the requirement that if the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations.		
Reinstatement of Services		
33. If the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i) MCO Contract: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 6 • S13_24.1_Medicaid Fair Hearing; page 5 • S13_33.2_Compliance Program Policy; page 2 • S13_33.2_MFH Metric Tracking; entire document **Additional Documentation:** • G & A Policy • Narrative	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: When a decision to deny, limit, or delay services is reversed by either Humana or the State Fair Hearing officer, and the member did not receive the disputed services during the appeal, Humana acts quickly to ensure compliance with requirements. The organization promptly authorizes or provides the necessary services, taking into consideration the urgency of the member's health needs, and ensures this occurs within 72 hours of receiving notice of the reversal. This process is supported by internal compliance monitoring and audit committees to uphold timely access to care and adherence to regulatory standards. The Grievance and Appeal Compliance Program includes regular reviews and feedback mechanisms to ensure that such authorizations are made within required timeframes and with a focus on member well-being.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The Grievance and Appeals policy did not include the requirement that if the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.		
Required Actions: The MCE must update the Grievance and Appeals policy to include the requirement that if the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.		
Grievances, Appeals, and State Fair Hearings		
34. In handling grievances and appeals, the MCE gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. 42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d) MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 11.4.1.1.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Example of assistance to members on filing a grievance **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; page 2 • S13_10.1_Dual Demo G+A; page 10 • S13_1.2_Member Handbook; page 17 • S13_34.3_Member Handbook; pages 24 & 25	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana ensures that members receive reasonable assistance when navigating the grievance and appeal process. The organization provides support with completing forms and procedural steps, addressing communication barriers by offering auxiliary aids and services as needed. This includes access to interpreter services for those with cultural or linguistic needs and the availability of a TTY line for members who are hearing impaired. Additional accommodations are made for members with special needs to ensure equitable access to the grievance process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
35. The MCE provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i) 42 CFR §457.1260(e)(1) MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 5.15.2; 5.15.3	**HSAG Required Evidence:** • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines • HSAG will also use the results of the Grievances and Appeals File Reviews **Evidence as Submitted by the MCE:** • S13_35.1_G+A Letter Job Aid; entire document • S13_35.1_Letter Readability; entire document • S13_35.2_Readability Guide; page 2 • S13_2.3_Aux Aids Notice; entire document • S13_2.3_Non-Discrimination Notice; entire document • S13_6.2_Grievance Res Letter; entire document • S13_24.3_Appeal Resolution Letter; entire document • S13_24.3_Overturn Resolution Letter; entire document	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
MCE Description of Process: Humana issues written notices of grievance and appeal resolutions in a manner that ensures accessibility and clarity for all members. These notices are provided in formats and languages that meet the requirements outlined, including alternative formats or auxiliary aids upon request to accommodate diverse needs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
36. The MCE provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. 42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g) MCO Contract: 2.9.29.7 PAHP Contract: 2.6.9.13 PIHP Contract: 11.6.6.1	**HSAG Required Evidence:** • Policies and procedures • Provider manual • Provider contract • Subcontractor agreement template **Evidence as Submitted by the MCE:** • S13_10.3_Provider Manual; pages 55-57 • S13_9.3_Provider Manual Narrative; entire document • S13_36.1_Physician Agreement; page 10 • S13_36.1_Narrative; entire document • S13_36.3_Provider Manual; pages 61-66 • S13_36.3_Physician Contract; page 11 • S13_36.3_Subcontractor Contract; pages 6 & 13 • S13_36.4_Delegation Addendum; entire document • S13_36.4_Subcontractor Reg Attachment; entire document • S13_36.4_Narrative; entire document	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • 2025 Provider Manual	
MCE Description of Process: Humana ensures that all providers and subcontractors receive comprehensive information about the grievance and appeal system at the time they enter into a contract. This information is included in the Louisiana Medicaid Regulatory Attachment, which is incorporated into all delegated entities' agreements. The attachment outlines the requirements, processes, and rights related to grievances and appeals, ensuring subcontractors are fully informed of their obligations and the procedures to follow.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
37. The MCE includes as parties to the appeal and SFH: a. The member and his or her representative. b. The legal representative of a deceased member's estate. c. For SFH, the MCE. 42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §457.1260(e)(5) MCO Contract: 2.15.3.1.6 PAHP Contract: 2.10.3.1.5 PIHP Contract: 11.4.2.4.2; 11.4.14.5	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and/or notice templates **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; pages 3 & 5 • S13_1.2_Member Handbook; page 26	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that all appropriate parties are included in the appeal and State Fair Hearing (SFH) processes. The parties to the appeal and SFH include the member and their authorized representative, as well as the legal representative of a deceased member's estate. For State Fair Hearings, Humana also participates as a party, providing necessary information and support throughout the proceedings.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recordkeeping Requirements		
38. Grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. PIHP: a. Medicaid number b. Summary of grievances and appeals; c. Current status; d. Resolution with date of resolution and resulting corrective action; e. The total number of grievances, appeals and State Fair Hearings held for the reporting period broken out by members and providers filing on behalf of members; f. The status and resolution of all claims disputes; g. Trends and types of grievances and appeals;	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Grievances and Appeals File Reviews and the system demonstration **Evidence as Submitted by the MCE:** • S13_1.1_G+A Policy; pages 3 & 5 **Additional Documentation:** • Grievance and Appeals Policy	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
h. The number of grievances and appeals in which the PIHP did not meet timely disposition or resolution; and i. The number of State Fair Hearings and resolution during the reporting period. 42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h) MCO Contract: 2.15.1.7 PAHP Contract: 2.10.1.7 PIHP Contract: 117.2		
MCE Description of Process: Humana ensures that all grievance and appeal records are maintained accurately and in an accessible manner, as required by regulatory guidance. Each record includes essential information such as a general description of the issue, the date received, and the dates of any reviews or review meetings. The records also document the resolution and the date of resolution at each level, if applicable, as well as the name of the member involved. These records are securely stored for at least ten years and are made available to the State and CMS upon request.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HUM's Grievance and Appeals policy did not include the requirement that the grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed.		
Required Actions: The MCE must update its Grievance and Appeals policy to include the requirement that the grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed.		

Results for Standard XIII—Grievance and Appeal Systems							
Total	Met	=	31	X	1	=	31
	Not Met	=	6	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	37	**Total Score**		=	31

Total Score ÷ Total Applicable	=	**84%**

Standard XIV—Program Integrity

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Certification		
1. Documentation or information the MCE submits to LDH is certified by the MCE's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. a. The certification provided by the individual must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful. b. The MCE submits the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b). 42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o) MCO Contract: None PAHP Contract: 3.3.4.3; 3.3.4.4 PIHP Contract: 16.1.4; 16.1.5; 16.1.6	**HSAG Required Evidence:** • Policies and procedures to certify the data specified in 42 CFR §438.604 • Position and job description of individual responsible for certification **Evidence as Submitted by the MCE:** • S14_1.1_MSR Oversight and Submission, page 1 • S14_1.2_VP MCD Regional President, entire document **Additional Documentation:** • Narrative Response • Report Data Certification SOP • Report Data Certification draft policy • Screenshot of Salesforce Platform • Signature Screenshots	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana ensures that all documentation and information submitted to the Louisiana Department of Health (LDH) is certified by an appropriately authorized executive, specifically the VP, Medicaid Regional President for Louisiana. This executive reports directly to senior leadership and is responsible for attesting that, to the best of their knowledge and belief, all submitted data is accurate, complete, and truthful. The certification is provided at the time of each submission, aligning with regulatory requirements.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Compliance Program/Program Integrity Plan		
2. The MCE develops a compliance program that includes: a. Written policies, procedures, and standards of conduct that articulate the MCE or subcontractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements. b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors. c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract. d. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees, for the Federal and State standards and requirements under the Contract. MCO and PAHP: a. *Fraud, waste, and abuse training shall include, but not be limited to:* i. *Annual training of all employees; and*	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan • Program Integrity (PI) Annual Work Plan • Compliance Officer job description • Organizational chart • Regulatory Compliance Committee charter • Compliance training plan • Compliance training materials • Training tracking mechanisms • Communication protocol for Compliance issues (e.g., hotline) • Code of Ethics • HSAG will also use findings from the Compliance Reporting/Tracking system demonstration **Evidence as Submitted by the MCE:** • S14_2.1_LA AFP Addendum, page 2 • S14_2.1_SIU Anti Fraud Plan, page 1-17 • S14_2.1_Louisiana Compliance Plan, page 1 • S14_2.1_Contract Compliance Officer, page 1	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
ii. *New hire training within thirty (30) Calendar Days of beginning date of employment.* b. *The MCO/PAHP shall require new employees to complete and attest to training modules within thirty (30) calendar days of hire related to the following in accordance with applicable Federal and State laws, regulations, rules, and policies:* i. *MCO/PAHP Code of Conduct Training;* ii. *Privacy and Security - Health Insurance Portability and Accountability Act;* iii. *Fraud, Waste, and Abuse identification and reporting procedures;* iv. *The False Claims Act and employee whistleblower protections;* v. *Procedures for Timely consistent exchange of information and collaboration with LDH;* vi. *Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and* vii. *Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant State and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by LDH, HHS, CMS, and OIG, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its agencies.*	• S14_2.2_Special Investigations Unit Plan, entire document • S14_2.2_Louisiana Compliance Plan, page 1 • S14_2.3_SIU Anti Fraud Plan, page 16 • S14_2.4_Compliance Office Job Description, entire document • S14_2.4_Compliance Director Job Description, entire document • S14_2.4_Contract Compliance Officer, entire document • S14_2.5_SIU Org Chart, entire document • S14_2.6_Medicaid Committee Charter 2024, entire document • S14_2.7_Special Investigations Unit Plan, pages 2,3,4,16 • S14_2.8_Ethics & Compliance, entire document • S14_2.8_Compliance_Program Narrative, entire document • S14_2.8_LA Contract Training, entire document • S14_2.9_Compliance Training PP, entire document • S14_2.9_Training Tracking Narrative, entire document • S14_2.10_SIU Anti Fraud Plan, page 18-19 • S14_2.11_EthicsEveryDay, entire document	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
c. *Effective lines of communication between the compliance officer and the organization's employees.* d. *Enforcement of standards through well-publicized disciplinary guidelines.* e. *Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.* PIHP: a. *Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;* b. *A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;* c. *Procedures for timely and consistent exchange of information and collaboration with LDH Program Integrity, LDH-OBH, the Louisiana Attorney General,*		

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Requirement	**Supporting Documentation**	**Score**
Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud; d. *Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly; and* e. *Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the PIHP. The PIHP shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible.* 42 CFR §438.608(a)(1) MCO Contract: 2.20.2.2.1; 2.20.2.2.2; 2.20.2.2.3; 2.20.2.2.4; 2.20.2.2.5; 2.20.2.2.6; 2.20.2.2.7 PAHP Contract: 2.12.5.2.1; 2.12.5.2.2; 2.12.5.2.3; 2.12.5.2.4; 2.12.5.2.5; 2.12.5.2.6; 2.12.5.2.7; 2.12.5.2.8; 2.12.5.2.9 PIHP Contract: 13.1.2.3.1; 13.1.2.3.2; 13.1.2.3.4; 13.1.2.3.5; 13.1.2.3.6; 13.1.2.3.7; 13.1.2.3.8; 13.1.2.3.9; 13.1.2.3.10; 13.1.2.3.11		
MCE Description of Process: Humana maintains a comprehensive compliance program that incorporates written policies, procedures, and standards of conduct, reflecting the organization's commitment to meeting all applicable federal and state requirements. A designated Compliance Officer is responsible for the development and implementation of these policies and reports directly to both the Chief Executive Officer and the Board of Directors, ensuring independent oversight and accountability. The organization has established a Regulatory Compliance Committee at both the Board and senior management levels, which provides ongoing oversight of the compliance program. Additionally, Humana implements a robust system for training and educating the Compliance Officer, senior management, and all employees on relevant federal and state standards, with training requirements tracked and documented to ensure ongoing adherence.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The arrangements and procedures of the compliance program must include all of the following elements: MCO and PAHP: a. *The MCO/PAHP implements procedures for a prompt response to detected offenses and for development of corrective action initiatives.* MCO Contract: 2.20.2.2.12 PAHP Contract: 2.12.5.2.12 PIHP Contract: 13.1.2.3.8	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan **Evidence as Submitted by the MCE:** • S14_3.1_SIU Anti Fraud Plan, pages 6,8,12,18,19 • S14_3.1_Louisiana Compliance Plan, page 2 • S14_3.2_Louisiana Compliance Plan, page 2 • S14_3.2_SIU Anti Fraud Plan, pages 6,8,12,18,19	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Humana's compliance program procedures ensure a prompt response to detected offenses related to fraud, waste, and abuse. When an allegation is received, the Special Investigations Unit (SIU) initiates a timely inquiry and, if warranted, conducts a comprehensive investigation using established protocols. Findings may lead to the development of corrective action initiatives, which are designed to address underlying issues, educate involved parties, and prevent future noncompliance. These actions are monitored and reviewed to ensure effectiveness and ongoing adherence to federal and state requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. Additional compliance program requirements: MCO: a. *The MCO's compliance program shall incorporate the following requirements:* i. *Detection and prevention of Louisiana Medicaid Program violations and possible fraud, waste, and abuse overpayments through data matching, trending, statistical analysis, monitoring service*	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan **Evidence as Submitted by the MCE:** • S14_4.1_LA AFP Addendum, page 4 • S14_4.1_SIU Anti Fraud Plan, pages 5-11	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
and billing patterns, monitoring claims edits, and other data mining techniques. ii. *Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including: lists of pre-payment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms, and references in provider and member materials relative to identifying and reporting fraud to the MCO and law enforcement.* iii. *Provisions for the confidential reporting of plan violations, such as a dedicated toll-free hotline to report violations and a clearly designated individual, such as the contract compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.* iv. *Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.* PAHP: a. *Detection and prevention of Medicaid program violations and possible fraud, waste and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.*	• S14_4.1_Onsite Audit Policy, entire document • S14_4.2_SIU Anti Fraud Plan, pages 5-11 • S14_4.2_LA AFP Addendum, page 4 • S14_4.2_Onsite Audit Policy, entire document	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
b. *Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste and abuse, including: lists of prepayment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms; and references in provider and member materials relative to identifying and reporting fraud to the plan and law enforcement.* c. *Provisions for the confidential reporting of plan violations, such as a dedicated hotline to report violations and a clearly designated individual, such as the Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.* d. *Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.* e. *Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to enrollees, providers, PAHP employees and the public on the PAHP's website required under the contract. The PAHP must implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *The PIHP's fraud, waste and abuse policies and procedures shall provide and certify that the PIHP's fraud, waste and abuse unit has access to records of providers.* i. *The PIHP shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the PIHP's senior management.* b. *Description of effective training and education for the compliance officer, the organization's employees, PIHP providers and members to ensure that they know and understand the provisions of the fraud, waste and abuse compliance plan and know about fraud and abuse and how to report it* c. *A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.* MCO Contract: 2.20.2.3 PAHP Contract: 2.12.5.3 PIHP Contract: 13.1.2.5; 13.1.2.11; 13.1.2.12		
MCE Description of Process: Humana's compliance program employs a range of proactive measures to detect and prevent violations, fraud, waste, and abuse within the Louisiana Medicaid Program. This includes the use of advanced data analysis techniques such as data matching, trending, statistical analysis, and ongoing monitoring of service and billing patterns, as well as claims edits and provider profiling algorithms. The organization maintains robust internal controls, including both pre-payment and post-payment claims edits and audits, and provides clear information to providers and members on how to identify and report potential fraud. Multiple confidential reporting channels are available, including a dedicated toll-free hotline and independent reporting paths, ensuring that concerns can be raised without interference. In addition, Humana has detailed policies and procedures for both announced and unannounced onsite provider audits to verify the accuracy of services rendered and billed.		

<table>
<tr><th colspan="3">Standard XIV—Program Integrity</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td>5. Publicized email address:
MCO and PAHP:
a. Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to Enrollees, providers, MCO/PAHP employees and the public on the MCO's/PAHP's website.
b. The MCO/PAHP shall implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.
MCO:
a. The MCO shall submit to LDH or its designee the fraud, waste, and abuse compliance plan as part of readiness review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) calendar days in advance of making them effective.
PAHP:
a. The PAHP shall submit the fraud and abuse compliance plan to LDH. The PAHP shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of the effective date. LDH, at its sole discretion, may require that the PAHP modify its compliance plan.
MCO Contract: 2.20.2.4; 2.20.2.5
PAHP Contract: 2.12.5.3.5; 2.12.5.4</td><td>HSAG Required Evidence:
• Policies and procedures
• Program Integrity Compliance Plan
• Evidence of publicized email address
Evidence as Submitted by the MCE:
• S14_5.1_LA AFP Addendum, page 4
• S14_5.2_LA AFP Addendum, page 4
• S14_5.3_Evidence of Publicized Email Address, entire document

Additional Documentation:
• Submission of Comp Plan to LDH</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
</table>

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PIHP Contract: NA		
MCE Description of Process: Humana maintains a well-publicized email address dedicated to the reporting of fraud, waste, and abuse, which is made readily available to enrollees, providers, employees, and the public on the organization's website.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Overpayments and Treatment of Recoveries		
6. The MCE implements and maintains arrangements or procedures for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to LDH. 42 CFR §438.608(a)(2) MCO Contract: 2.20.2.2.15 PAHP Contract: 2.12.5.2.15 PIHP Contract: 13.1.2.3.9	**HSAG Required Evidence:** • Policies and procedures, including timeline for prompt reporting of overpayments • Special investigations unit (SIU) workflows • Identification mechanisms • Reporting mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials **Evidence as Submitted by the MCE:** • S14_6.1_LA AFP Addendum, page 4 • S14_6.2_Overpayments SIU Workflow, entire document • S14_6.3_Overpayment Policy, entire document • S14_6.4_PI 145 FWA Report, entire document • S14_6.5_LA Provider Manual, page 47 • S14_6.5_LA Narrative_Provider Manual, entire document	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• S14_6.5_2024 Provider Agreement, page 12 • S14_6.6_LA Contract Training, entire document **Additional Documentation:** • S14_7.5_Q1 LA FWA Quarterly Report, entire document	
MCE Description of Process: Humana maintains robust procedures to promptly identify, report, and recover any overpayments, including those potentially related to fraud. Upon detection of an overpayment, providers are required to notify Humana within 60 days and submit a written explanation for the overpayment. Humana, in turn, reports all identified and recovered overpayments to the Louisiana Department of Health (LDH) within the required timeframes, ensuring transparency and regulatory compliance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. The MCE follows the retention policies for the treatment of recoveries of all overpayments from the MCE to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. a. The MCE complies with the process, timeframes, and documentation required by LDH for reporting the recovery of all overpayments. b. The MCE complies with the process, timeframes, and documentation LDH requires for payment of recoveries of overpayments to LDH in situations where the MCE is not permitted to retain some or all of the recoveries of overpayments. c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.	**HSAG Required Evidence:** • Policies and procedures • Overpayment tracking mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials • Most recent report of recoveries of overpayments to State **Evidence as Submitted by the MCE:** • S14_7.1_Overpayment Policy, pages 1-3 • S14_7.1_LA AFP Addendum, page 5 • S14_7.1_Addendum to Overpayment Policy, pages 1-2	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCO: a. *Report annually to LDH, in a form and format specified by LDH, on the MCO's recoveries of overpayments in accordance with 42 CFR §438.608.* PAHP: a. *The PAHP shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified.* b. *The PAHP shall report to LDH Program Integrity at least monthly all unsolicited provider refunds, to include any payments submitted to the Contractor and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.* PIHP: a. *The Contractor shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its providers and subcontractors. Reporting must specify which overpayments are attributed to potential fraud.* b. *The PIHP shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.* 42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3) MCO Contract: 2.20.2.2.15; 2.20.7.3 PAHP Contract: 2.12.2.4; 2.12.5.2.15; 2.12.6.3.1.4; 2.12.6.3.1.5; 6.3.6.3; 2.12.6.3.2; 2.12.6.3.3; 2.12.6.3.4 PIHP Contract: 13.5.5; 13.5.6	• S14_7.2_Overpayment Policy, pages 1,3 • S14_7.2_Addendum to Overpayment Policy, page 2 • S14_7.2_LA AFP Addendum, page 5 • S14_7.3_LA Provider Manual, page 47 • S14_7.3_LA Narrative_Provider Manual, entire document • S14_7.4_Staff Training Narrative, entire document • S14_7.4_145 Guideline Waste and Error Tab, entire document • S14_7.4_145 Guideline Fraud and Abuse Tab, entire document • S14_7.5_Q1 LA FWA Quarterly Report, entire document	

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana implements comprehensive processes to ensure the identification, recovery, and reporting of overpayments, including those resulting from fraud, waste, or abuse. The organization adheres to the required procedures, timeframes, and documentation set forth by the Louisiana Department of Health (LDH) for both the recovery and reporting of overpayments. When recoveries must be remitted to LDH, Humana follows the specified protocols to ensure accurate and timely payment. Overpayment activities are tracked and reported annually.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The MCE requires and has a mechanism for a network provider to report to the MCE when it has received an overpayment, to return the overpayment to the MCE within 60 calendar days after the date on which the overpayment was identified, and to notify the MCE in writing of the reason for the overpayment. 42 CFR §438.608(d)(2) MCO Contract: 2.20.2.2.14 PAHP Contract: 2.12.5.2.14 PIHP Contract: 3.1.12	**HSAG Required Evidence:** • Policies and procedures • Overpayment and monitoring mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials **Evidence as Submitted by the MCE:** • S14_8.1_Addendum to Overpayment Policy, entire document • S14_8.2_Overpayments SIU Workflow, entire document • S14_8.2_Addendum to Overpayment Policy, entire document • S14_8.2_Overpayment Policy, entire document • S14_8.3_LA Narrative_Provider Manual, entire document • S14_8.3_LA Provider Manual, page 47 • S14_8.4_Overpayment and Recoveries Staff Training, entire document	☒ Met ☐ Not Met ☐ NA

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<tr><th colspan="3">Standard XIV—Program Integrity</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">MCE Description of Process: Humana has established clear procedures for network providers to report and return any identified overpayments within 60 calendar days of discovery. Providers are instructed to locate the relevant claim within the Availity Essentials portal and utilize the “Identify Overpayment” function, following guided prompts to submit the required information. In addition to returning the overpayment, providers must include a written explanation specifying the reason for the overpayment. Staff receive comprehensive training on these processes, emphasizing the importance of compliance with regulatory requirements and proper documentation.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><th colspan="3">Notification of Member and Provider Changes</th></tr>
<tr><td>9. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for prompt notification to LDH when it receives information about changes in a member’s circumstances that may affect the member’s eligibility including all of the following:
a. Changes in the member’s residence;
b. The death of a member.
42 CFR §438.608(a)(3)
MCO Contract: 2.20.2.2.8
PAHP Contract: 2.12.5.2.10
PIHP Contract: 14.8.1.4</td><td>HSAG Required Evidence:
• Policies and procedures
• Staff training materials
Evidence as Submitted by the MCE:
• S14_9.1_Demographic Changes, entire document
• S14_9.2_GuidingCare Training, entire document

Additional Documentation:
• LA Demo Change Report May 17 2024
• LA Demo Change Report May 2024
• Narrative</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td colspan="3">MCE Description of Process: Humana has established clear procedures to ensure timely notification to the Louisiana Department of Health (LDH) when changes in a member’s circumstances that may impact eligibility are identified. When a member’s address or residence changes, Customer Care Advocates update the information in the internal system, and the Enrollment IT team reports these updates to LDH within five business days. Similarly, when notified of a member’s death, the information is verified, recorded in the system, and promptly communicated to LDH according to required timelines.</td></tr>
</table>

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for notification to LDH when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCE. PAHP: a. *The PAHP shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for enrollees due to provider illness, a provider dies, the provider moves from the service area and fails to notify the PAHP, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network. The notification shall include:* i. *Information about how the provider network change will affect the delivery of covered services; and* ii. *The PAHP's plan for maintaining the quality of enrollee care if the provider network change is likely to affect the delivery of covered services.* PIHP: a. *The PIHP shall notify LDH within one (1) business day of the PIHP becoming aware of any unexpected changes (e.g., a provider becoming unable to care for*	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • S14_10.1_Medicaid Fraud Notifications, page 1 • S14_10.2_Provider Alert Staff Training Materials, entire document	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include: i. *Information about how the provider network change will affect the delivery of covered services, and* ii. *The PIHP's plan for maintaining the quality of member care if the provider network change is likely to affect the delivery of covered services.* 42 CFR §438.608(a)(4) MCO Contract: 2.20.2.2.9 PAHP Contract: 2.6.7.6; 2.12.5.2.11 PIHP Contract: 6.6.5		
MCE Description of Process: Humana has established comprehensive procedures to promptly notify the Louisiana Department of Health (LDH) when there is a change in a network provider's circumstances that could impact their eligibility to participate in the managed care program, such as the termination of a provider agreement. Upon receiving information indicating the need for provider payment suspension or eligibility change, the Payment Integrity Team documents the alert and ensures all relevant business areas are informed within one business day. Notification to LDH is carried out through approved secure channels, with all required details and supporting documentation provided in accordance with LDH guidelines. Staff receive dedicated training on these processes, including documentation and tracking requirements, to ensure timely and accurate communication.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Verification of Services Provided		
11. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for	**HSAG Required Evidence:** • Policies and procedures	☒ Met

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis. MCO: a. *On a monthly basis, the MCO shall provide individual explanation of benefits (EOB) notices to a sample group of Enrollees, not more than forty-five (45) calendar days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice shall specify:* i. *Description of the service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished;* iv. *The amount of the payment made for the service; and* v. *The method for notifying the Contractor of services not rendered.* b. *The Contractor shall stratify the paid Claims sample to ensure that all provider types (or specialties) and all Claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the Contractor or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid Claims sample shall be a*	• Methodology for verifying services • Most recent results from the Medicaid verification of services activity • Staff training materials **Evidence as Submitted by the MCE:** • S14_11.1_Verification of Services, pages 1-2 • S14_11.2_Verification of Services, pages 1-2 • S14_11.3_Sampling of Paid Claims Report, entire document • S14_11.4_Medicaid Verification of Services, pages 1-2 • S14_11.4_Service Verifications Staff Training, entire document	☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
minimum of two percent (2%) of paid Claims per month to be reported to LDH on a quarterly basis. c. *The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).* d. *The Contractor shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be effected through member education, provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.* e. *Within three (3) business days of receipt of a response from an enrollee, results indicating that paid services may not have been received shall be referred to the MCO's fraud and abuse department for review and to the LDH Program Integrity contact.* f. *Reporting shall include, at a minimum, the total number of notices sent to enrollees, total number of services sent for validation, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to LDH for further review.* PAHP: a. *On a monthly basis, the PAHP shall provide individual explanation of benefits (EOB) notices to a sample group of members, not more than forty-five (45) days from the date of payment, in a manger that complies with 42*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify: i. *Description of the service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished; and* iv. *The amount of the payment made for the service.* b. *Stratify paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the DBPM or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over sample the group. The paid claims sample should be for a minimum of two (2%) percent of claims paid per month to be reported on a quarterly basis.* c. *The PAHP shall also perform surveys at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits); and* d. *Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures.* e. *Within three (3) business days, results indicating that paid services may not have been received shall be referred to the PAHP's fraud and abuse department for review and to the LDH Program Integrity contact.* f. *Reporting shall include the total number of survey notices sent out to enrollees, total number of surveys*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
completed, total services requested for validation, number of services validated, analysis of interventions related to complaint resolution, and number of surveys referred to LDH for further review. PIHP: a. *On a monthly basis, the Contractor shall provide individual EOB notices to a sample group of the members who received services, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). The required notice must specify:* i. *The service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished; and* iv. *The amount of the payment made for the service.* b. *The Contractor shall stratify the sample to ensure that all provider types are represented in the same pool. The sample should be a minimum random sample of at least sixty-five (65) members per month who received a paid service to be reported on a quarterly basis. The Contractor shall submit the methodology to LDH for prior approval.* c. *Surveys shall be performed within forty-five (45) days after a claim has been paid. This sampling may be performed by mail, telephonically, or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
d. *The Contractor shall over sample particular provider groups upon request by LDH.* e. *The Contractor shall track any feedback received from members. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.* f. *Within five (5) business days, results indicating that paid services may not have been received shall be referred to the Contractor's fraud and abuse department for review and to LDH's designated Program Integrity contact.* g. *The Contractor shall provide a quarterly report to LDH regarding the EOB results from sample group notices in a format to be approved by LDH. This report shall include attestations certifying EOBs were developed and sent to beneficiaries, and that the beneficiaries were provided sixty (60) days for comment and suggestion. The attestation form will be provided by LDH.* 42 CFR §438.608(a)(5) MCO Contract: 2.20.2.2.10; 2.18.11.1 PAHP Contract: 2.14.6. PIHP Contract: 15.4		
MCE Description of Process: Humana maintains a robust process to verify that services billed by network providers were actually received by members, in accordance with regulatory requirements. Each month, a stratified random sample representing at least four percent of paid claims is selected to ensure all provider types and specialties are included. Individual Explanation of Benefits (EOB) notices are sent to sampled enrollees within forty-five days of payment, clearly describing the service, provider, date, payment amount, and instructions for reporting services not received. Responses are closely tracked and addressed through established procedures, including member or provider education, payment recovery, or referral to the appropriate authorities. All results, including the volume of notices, responses, validations, and any		

<table>
<tr><th colspan="3">Standard XIV—Program Integrity</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td colspan="3">referrals, are systematically reported to the Louisiana Department of Health on a quarterly basis, supporting ongoing program integrity and compliance.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td colspan="3">Whistleblower Protection</td></tr>
<tr><td>12. In the case of MCEs that make or receive annual payments under the contract of at least $5,000,000, the MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.
MCO:
a. Include in any employee handbook for the MCO, a specific discussion of the laws, the rights of employees to be protected as whistleblowers and the MCO’s policies and procedures for detecting and preventing fraud, waste and abuse.
42 CFR §438.608(a)(6)
MCO Contract: 6.18.1; 6.18.3
PAHP Contract: 2.12.5.2.6.4; 2.12.5.2.6.7
PIHP Contract: 13.1.1.2.; 13.1.2.8</td><td>HSAG Required Evidence:
• Policies and procedures
• Program integrity/compliance plan
• Staff, Provider, and Subcontractor training/informational materials

Evidence as Submitted by the MCE:
• S14_12.1_Special Investigations Unit Anti-Fraud Plan, entire document
• S14_12.2_Louisiana Compliance Plan, entire document
• S14_12.2_SIU Anti Fraud Plan, pages 3,16
• S14_12.3_Ethics-Whistleblower, page 8</td><td>☒ Met
☐ Not Met
☐ NA</td></tr>
</table>

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Humana has established comprehensive written policies and procedures that inform all employees, contractors, and agents about the False Claims Act and other applicable federal and state laws addressing fraud, waste, and abuse. These policies provide detailed information on the rights and protections afforded to whistleblowers, ensuring employees are aware of their ability to report suspected misconduct without fear of retaliation. This information is included in the employee handbook and covered during onboarding and annual compliance training.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Fraud, Waste, and Abuse		
13. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures: a. That are designed to detect and prevent fraud, waste, and abuse. b. For the prompt referral of any potential fraud, waste, or abuse that the MCE identifies to LDH's program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (MFCU). PAHP: a. *The PAHP shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state office and Attorney General Medicaid Fraud Control Unit (MFCU) and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).*	**HSAG Required Evidence:** • Policies and procedures • Fraud, waste, and abuse plan • SIU workflow • Reporting mechanisms • Staff training materials **Evidence as Submitted by the MCE:** • S14_13.1_SIU Anti Fraud Plan, pages 1,5,8 • S14_13.1_LA AFP Addendum, page 3 • S14_13.2_SIU Anti Fraud Plan, pages 1,5,8 • S14_13.2_LA AFP Addendum, page 3 • S14_13.3_SIU Referral Workflow, entire document • S14_13.4_Fraud Referral Template, entire document • S14_13.5_Ethics & Compliance, page 28	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *The PIHP shall establish policies and procedures for referral of suspected fraud, waste and abuse to the LDH Program Integrity Office and Law Enforcement. A standardized referral process should be developed to expedite information for appropriate disposition.* 42 CFR §438.608(a) 42 CFR §438.608(a)(7) MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4	**Additional Documentation:** • Excerpt Language • Narrative	
MCE Description of Process: Humana has established comprehensive arrangements and procedures to effectively detect and prevent fraud, waste, and abuse (FWA) across its operations. The Special Investigations Unit (SIU) employs a range of proactive measures, including data mining, statistical analysis, and review of claims and provider activities, to identify potential FWA. When potential FWA is identified, the SIU promptly initiates a reasonable inquiry and, if warranted, refers the matter—using a standardized referral template and process—to the appropriate authorities, including the LDH program integrity unit or the State Medicaid Fraud Control Unit (MFCU). This referral includes detailed investigative findings, supporting documentation, and outlines any corrective actions taken.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Suspension of Payments		
14. The MCE, and all applicable subcontractors, implements and maintains arrangements or procedures for the suspension of payments to a network provider for which LDH determines there is a credible allegation of fraud in accordance with 42 CFR §455.23. 42 CFR §438.608(a)(8) 42 CFR §455.23 MCO Contract: 2.20.2.2.11	**HSAG Required Evidence:** • Policies and procedures • Payment suspension workflow • Staff training materials **Evidence as Submitted by the MCE:** • S14_14.1_Medicaid Fraud Notifications, page 1	☒ Met ☐ Not Met ☐ NA

<table>
<tr><th colspan="3">Standard XIV—Program Integrity</th></tr>
<tr><th>Requirement</th><th>Supporting Documentation</th><th>Score</th></tr>
<tr><td>PAHP Contract: 2.12.2.2
PIHP Contract: 13.5.22</td><td>• S14_14.2_Payment Suspension Workflow, entire document
• S14_14.3_Payment Suspensions Guideline Training, whole document
• S14_14.3_Medicaid Fraud Notifications, page 1</td><td></td></tr>
<tr><td colspan="3">MCE Description of Process: Humana has established detailed procedures for implementing payment suspensions to network providers when notified by the Louisiana Department of Health (LDH) of a credible allegation of fraud. Upon receiving a provider alert from LDH, the Program Integrity team promptly reviews the notification, organizes the relevant documentation, and ensures that payment suspension rules are correctly applied to the provider's record. Notification letters are sent to affected providers via trackable mail, and all related actions and communications are documented and tracked within secure systems. The process includes coordination among compliance, claims, network operations, and other business areas to ensure timely response and accurate implementation of payment suspensions or their release.</td></tr>
<tr><td colspan="3">HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</td></tr>
<tr><td colspan="3">Required Actions: No action required.</td></tr>
<tr><td rowspan="2">15. The MCE, and all applicable subcontractors, issues a notice of payment suspension that comports with 42 CFR §455.23(b) and retains the suspension in accordance with 42 CFR §455.23(c).
42 CFR §438.608(a)(8)
42 CFR §455.23

MCO Contract: 2.20.1.11.7
PAHP Contract: 2.12.2.2
PIHP Contract: 13.5.19</td><td>HSAG Required Evidence:
• Policies and procedures
• Payment suspension workflow, including applicable timeframes
• Notice of payment suspension letter template
• Staff training materials
• HSAG will also use findings from the provider payment suspensions tracking system demonstration</td><td rowspan="2">☒ Met
☐ Not Met
☐ NA</td></tr>
<tr><td>Evidence as Submitted by the MCE:
• S14_15.1_Payment Suspensions 2024, page 1
• S14_15.2_Payment Suspension Workflow, entire document</td></tr>
</table>

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	• S14_15.3_Payment Suspension Letter Template, entire document • S14_15.4_Payment Suspensions Guideline Training, entire document	
MCE Description of Process: Humana has established a structured process for issuing notices of payment suspension in response to notifications from the Louisiana Department of Health. Upon receipt of a payment suspension request, the Program Integrity team promptly distributes the notification to all relevant business areas and vendors, who take action within three business days to ensure that claims are not paid and to send a provider notification letter via certified mail. The letter communicates the suspension and termination details to the provider, including instructions for facilitating the transfer of medical records. All communications, notifications, and actions taken are meticulously documented and securely retained, ensuring that both issuance and retention requirements are met.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Provider Screening and Enrollment Requirements		
16. The MCE ensures that all network providers are enrolled with LDH as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E. 42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E MCO Contract: 2.9.7.1 PAHP Contract: 2.6.3.1 PIHP Contract: 6.53	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment verification workflow • Two examples of documented Medicaid enrollment verifications • Staff training materials **Evidence as Submitted by the MCE:** • S14_16.1_Policy_Cred, pages 33,34 • S14_16.2_Facility Recred Workflow, entire document • S14_16.2_Practitioner Cred.Recred Workflow, entire document	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	• S14_16.3_ID Verification, entire document • S14_16.3_ID Verification 2, entire document • S14_16.4_Medicaid Enrollment Verification, entire document • S14_16.5_Network Provider Terminations, entire document	
MCE Description of Process: Humana has established robust processes to ensure that all network providers are properly enrolled with the Louisiana Department of Health (LDH) as Medicaid providers, in accordance with the provider disclosure, screening, and enrollment requirements. Before contracting or reimbursing claims, Humana verifies each provider's enrollment status, conducts regular exclusion checks, and requires submission of necessary ownership, control, and credentialing documentation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days. a. The MCE terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or the expiration of the 120 day period without enrollment of the provider, and notify affected members. 42 CFR §438.602(b)(2) MCO Contract: 2.9.7.2 PAHP Contract: 2.6.9.1 PIHP Contract: 6.5.5	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment timeliness tracking mechanisms • Staff training materials **Evidence as Submitted by the MCE:** • S14_17.1_LA Cred and ReCred, page 39 • S14_17.1_Network Provider Terminations, entire document • S14_17.1_Medicaid Fraud Notifications, pages 2,5 • S14_17.2_CRM Platform Screenshots, entire document	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	• S14_17.2_APEX Terminations Tracking Mechanism, entire document • S14_17.2_Provider Enrollment Tracking Mechanism, entire document • S14_17.2_APEX Medicaid Terminations, entire document • S14_17.3_LDH Portal Enrollment Process, entire document	
MCE Description of Process: Humana utilizes a detailed process for managing network provider enrollment and agreements. Provider agreements may be executed pending the outcome of screening, enrollment, and revalidation for up to 120 days, during which enrollment status is closely monitored using the CRM and APEX tracking systems. If notification is received from the Louisiana Department of Health (LDH) that a provider cannot be enrolled, or if the 120-day period expires without enrollment, Humana promptly terminates the provider from the network and ensures that affected members are notified. All actions, correspondence, and status changes are thoroughly documented within the organization's tracking platforms to maintain compliance and transparency.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Disclosures and Prohibited Affiliations		
18. The MCE, and any subcontractors: a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610. b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104.	**HSAG Required Evidence:** • Policies and procedures that apply to provider/contracted entities and the MCE • Provider materials, such as contract template or provider manual (requiring disclosures within 35 days after any change in ownership) • Disclosure of ownership and control notice template (required for completion by contracted entities)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
c. Reports to LDH within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. MCO: a. *Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars ($25,000), even if there is no suspicion of fraudulent activity.* 42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610 MCO Contract: 2.20.3.6; 2.20.7.2 PAHP Contract: 6.7.3.1; 2.15.12 PIHP Contract: 13.2.1; 13.2.2.1; 13.1.2.13	• Confirmation MCE disclosures were provided to LDH upon contract execution • Staff training materials **Evidence as Submitted by the MCE:** • S14_18.1_LA Provider Manual, pages 14-16 • S14_18.1_LA Narrative_Provider Manual, entire document • S14_18.1_Provider Agreement, pages 13-14 • S14_18.2_LA Provider Manual, pages 48 • S14_18.2_LA Narrative_Provider Manual, entire document • S14_18.2_Provider Agreement, page 3, 13-14 • S14_18.3_Disclosure of Ownership, entire document • S14_18.4_Disclosure of Ownership 2022, entire document • S14_18.5_Program Integrity Narrative, entire document • S14_18.5_CCM Overpayment, page 3	
MCE Description of Process: Humana maintains robust procedures to ensure compliance with federal and state requirements regarding program integrity and transparency. The organization provides written disclosures of any prohibited affiliations, as well as detailed disclosures of ownership and control information as required. Additionally, Humana monitors payments and reports to the Louisiana Department of Health within 60 calendar days if capitation or other payments are identified in excess of contractually specified amounts. The company also notifies LDH in writing upon receipt of any voluntary provider disclosures resulting in overpayments exceeding $25,000, regardless of whether there is suspicion of fraudulent activity.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Results for Standard XIV—Program Integrity							
Total	Met	=	18	X	1	=	18
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	18	**Total Score**		=	18

Total Score ÷ Total Applicable	=	**100%**

Appendix C. 2025 Corrective Action Plan Template

<table>
<tr><th colspan="4">Standard <#></th></tr>
<tr><th>Requirement</th><th colspan="2">Evidence as Submitted by the MCE</th><th>Score</th></tr>
<tr><td>1.
<Insert federal CFR citation>
Contract: <Insert Citation(s)></td><td colspan="2">MCE Document Submission:
•</td><td>☐ Met
☐ Not Met</td></tr>
<tr><td colspan="4">HSAG Findings:</td></tr>
<tr><td colspan="4">Required Actions:</td></tr>
<tr><th>Interventions Planned</th><th>Intervention Evaluation Method</th><th>Individual(s) Responsible</th><th>Proposed Completion Date</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">CAP Approval Status:</td></tr>
<tr><td colspan="4">Submission:</td></tr>
</table>