C. Technical Approach

17. Provider Services (*Section 27 Provider Services*)

With more than five decades of experience serving Kentuckians, and through our experience serving more than 900,000 Enrollees in Kentucky today, Humana has developed strong relationships with local providers. Our provider support activities are an extension of these longstanding relationships and have been tailored to meet the unique needs of the Enrollees and providers who participate in the Kentucky Medicaid Managed Care (MMC) program. We partner with and support a full spectrum of Commonwealth providers, ranging from large integrated delivery systems (such as Norton Healthcare) to large, multi-specialty clinics (such as Lexington Clinic) as well as small, rural, single-provider practices across the Commonwealth. Additionally, **100% of the Commonwealth's Federally Qualified Health Centers (FQHC), Community Mental Health Centers (CMHC), and Acute Care and Critical Access Hospitals participate in Humana's Medicaid provider network**. Our comprehensive, high-touch provider services model is designed to allow us to partner with providers meeting the unique needs of Commonwealth residents and support providers in the evolution and transformation of their practices. This intentional high-touch model also supports provider recruitment and retention activities. We highlight the core strategies of our provider services model below and elaborate on our expansive, high-touch functions on the ensuing pages of this response. Our core strategies include:

> **"Humana is a vital part of our Eastern Kentucky practice, providing personalized services for our doctors, staff, and our patients. The union we share assuredly produces high quality healthcare and positive outcomes for everyone involved. Their exceptional commitment is unmatched by other insurance companies."**
>
> – Debbie Emmons, Morehead Primary Care

- Provide administrative simplicity through seamless credentialing processes and minimal prior authorization (PA) requirements
- Offer practice transformation incentives (PTI) to enhance data-sharing capabilities and increase provider participation in value-based payment (VBP) arrangements
- Ensure provider satisfaction by addressing concerns in a timely manner and incorporating feedback into our operational improvement initiatives
- Support the integration of behavioral health (BH) and physical health to promote complete person-centric well-being
- Address geographic barriers to care by leveraging community and provider partnerships that increase the utilization of telehealth

a. Summarize the Vendor's overall approach to Provider Services, including initiatives and processes for providing effective services to providers to support the Kentucky Medicaid program. In the response, address the following at a minimum:

Our longstanding Kentucky presence provides us with a thorough understanding of the diverse and complex challenges our providers face throughout the unique service regions of the Commonwealth. Humana offers a comprehensive strategy to support our provider network in addressing these issues, beginning with our initial recruitment discussions and credentialing processes and continuing throughout the provider's path toward value-based care. Our Kentucky provider services model spans Humana's entire locally-based operations – from provider contracting to our Provider Relations representatives to our Louisville-based Provider Services Call Center – that work in concert to reduce administrative burden. Our model incorporates best practices from our

years of experience in the Commonwealth, which includes survey feedback from Kentucky providers, as well as the Department's requirements.

OVERALL APPROACH TO PROVIDER SERVICES

Humana's Provider Services Model comprised of our Provider Network, Provider Services Call Center, and Provider Relations Teams. Our provider-facing associates are described in detail on the ensuing pages and are led by the following individuals:

- Provider Services Leader: Our Provider Services Leader, Mary Sanders, provides end-to-end oversight of the Medicaid provider experience, supporting the identification and implementation of best practices across our national Medicaid provider organization. The Provider Services Leader chairs our monthly Provider 360 Committee meetings, a cross-functional committee whose mission is to improve provider engagement and satisfaction across all of our Medicaid service regions, to ensure sharing of information across the provider services function.
- Provider Network Director: Our Provider Network Director, Majid Ghavami, oversees all provider services and network development functions and will provide oversight of our coordinated efforts with the Department's contracted credentialing verification organizations (CVO) as well as lead Humana's workforce development initiatives in conjunction with the Department and other awarded Managed Care Organizations (MCO).
- Provider Services Manager: Our Provider Services Manager, Michelle Weikel, RN, CCM, works collaboratively with our Provider Network Director to implement our network development strategies. Additionally, they lead oversight of all Provider Services staff functions, including our Provider Services Call Center and the development of provider education materials.

Figure I.C.17-1 Provider Support Model

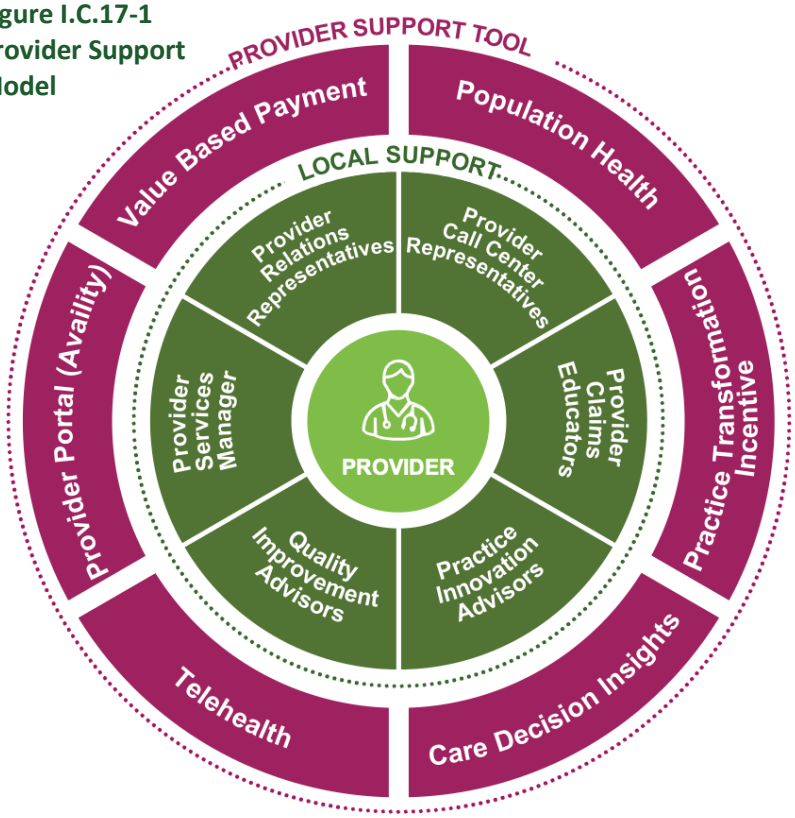


Figure I.C.17-1 presents a visual overview of our Provider Support model comprised of specialized Humana experts, who work in tandem to offer an optimal provider experience for our network.

INNOVATIVE INITIATIVES AND PROCESSES

We actively monitor provider satisfaction measures such, as feedback to our Provider Relations representatives, input from our Provider Advisory Committee (PAC), Voice of the Customer Surveys (VOC), interactions with our Provider Services Call Center and Provider Payment Integrity unit associates, and our Net Promoter Score. Combined with provider grievances and appeals, these measures inform our process improvement decisions. Humana has implemented the following initiatives and processes in the Commonwealth to support and enhance providers' experience serving our Enrollees:

Gold Carding

Humana's Gold Card program is aimed at increasing provider simplification and reducing providers' administrative obligations. Our Gold Card Program uses a blend of quality and performance measures to identify the highest-performing providers. Through reviewing provider's quality (using Humana's Care Highlights program) and utilization (percent of authorizations approved), we can identify those providers who deliver high-value care, close care gaps, and refer Enrollees for appropriate services and follows ups. When high-performing providers meet specific targets for certain measures, they will have the ability to bypass the standard outpatient PA process for the following services: referrals for specialty care, in-office or ambulatory surgery procedures prevalent with specialty providers, small molecule prescription (Rx) products, high-cost biologics, and high-tech imaging (CT/MRI). This program helps us achieve mutual quality and access goals while reducing the administrative burden on providers. We will be initiating a pilot of our Gold Card program for Kentucky Medicaid providers with an expected rollout in early 2021.

Care Decision Insights

The Care Decision Insights platform provides in-depth reviews of performance measures for efficiency and effectiveness of specialist groups based on claims data. These data can assist Primary Care Providers (PCP) in determining where to refer Enrollees while giving specialists an in-depth view of their performance. The data also generate an effectiveness and efficiency ranking that is listed in our Provider Directory. Specialty providers partner with PCPs to manage the complex needs of our Enrollees. To facilitate this partnership, our Quality Improvement Advisors (QIA) will share specialty provider profiles with PCPs to inform them of specialists' performance in delivering Enrollee care.

Telehealth Coordination

Telehealth and remote monitoring technologies support providers, particularly those in rural areas of the Commonwealth, by improving collaboration with Enrollees who are difficult to connect to care. In addition to other telehealth platforms, Humana has partnered with Arcadian Telepsychiatry, LLC to provide BH services to Enrollees through onsite telehealth consultation rooms located in primary care practices. During their quarterly onsite visits, as well as monthly telephonic or email communications, our Provider Relations representatives identify any barriers providers are facing regarding implementation of telehealth services. Provider Relations representatives then connect with our Practice Innovation Advisor to develop solutions to address these barriers, such as offering a Practice Transformation Incentive to purchase telehealth technologies for the provider practice.

Humana is supporting the advancement of Norton Healthcare's **school-based telemedicine program** in Jefferson County Public Schools, which allows Norton to remotely examine students with the assistance of a school nurse.

Value-Based Payment Support

Humana provides an array of personnel support, actionable data, and predictive models to better enable providers transitioning through our continuum of VBP programs. Our Population Health Management tool, Population Insights Compass (Compass), uses metrics to evaluate provider performance on access to care, delivery of preventive services, adherence to treatment, and medication and management of complex conditions. Through these reports, we seek to provide a fair and accurate representation of how providers are meeting evidence-based standards of care. Quality Improvement Advisors work closely with each practice's clinical team to interpret the reports and develop corrective action steps to improve quality, close care gaps, and meet VBP targets. Additionally, Our Medical Record Management application enables seamless **sharing of medical record information, including Admissions, Discharge, and Transfer (ADT) data in near real time**, between healthcare providers and our care management teams through our direct connection with electronic health records (EHRs).

Practice Transformation Incentive (PTI)
As part of our value-based program offering, we will establish a Practice Transformation Incentive in the Commonwealth to enhance access to care and improve quality. This incentive is a time-limited payment for a mutually agreed-upon practice infrastructure improvement investment. Our provider partners may request this incentive and collaborate with our Practice Innovation Advisor to maximize its potential to impact care delivery. The Practice Innovation Advisor works closely with providers in receipt of the PTI to invest the funds into their practices to improve their infrastructure and implement transformative initiatives that otherwise might be challenging to finance. Providers can use the PTI to add a BH provider, hire physician extenders, set up telehealth equipment, employ a patient navigator, or improve infrastructure. **For example, we recently gave a large multi-specialty provider group a PTI to establish a PAC to improve overall performance, particularly financial performance, and do a deep dive into data to develop a shared risk program**. Our Practice Innovation Advisor provides data support, targeted education, and training to maximize the PTI investment and ensure proper oversight of the funds.

a.i. A description of how provider representatives engage with providers initially and on an ongoing basis, including level of local presence and onsite visits to provider locations.

Our local Provider Relations representatives establish consistent, reliable, one-on-one relationships with providers, serving as a single point-of-contact. Provider Relations representatives leverage the expertise of Humana associates in areas such as claim denials, quality improvement strategies, and innovative practice transformation. Together, these experts ensure providers have all the resources and support needed to offer our Enrollees the highest quality of care. **Humana's local Provider Relations Team will be comprised of 25 associates across the Commonwealth**.

ASSOCIATE SPOTLIGHT: Michelle Weikel, RN, BSN, CCM

Michelle is proud to be the Provider Services Manager in Kentucky. She was born in Owensboro, Kentucky, but has lived in Louisville most of her life. Michelle has been a nurse for 25 years and a certified case manager for 20 years. She attended the University of Louisville where she earned a Bachelor of Science in Nursing. During her more than 23 years with Humana, she's worked across a variety of clinical, network, Information Technology, and provider-focused roles. In commenting on her role as the Provider Services Manager and on the mission of her team, she says, "We strive to meet providers where they are and make it easier for them to effectively care for and manage Humana Enrollees. We work closely with providers to address claims and service issues, but also offer actionable data and tools to impact their Humana Enrollees' clinical and quality outcomes."

INITIAL ENGAGEMENT WITH PROVIDERS

Within 30 days of contracting with Humana, a provider is contacted by their assigned Provider Relations representative so they can begin developing a personalized relationship. The Provider Relations representative serves as their single point-of-contact and will schedule onsite meetings so the provider can begin the required training and orientation, understand our integrated care model, and learn how to access our resources. We continuously enhance our provider education program, adjusting to changing programmatic requirements and provider feedback. We incorporate Medicaid-specific education, including the topics described in **Section 27.5 of the Draft Medicaid Contract, as well as in our response in sub-question I.C.17.a.iii**.

ONGOING PROVIDER ENGAGEMENT

We use multiple channels to comprehensively support and educate providers on an ongoing basis as they deliver care to our Enrollees. Our Kentucky-based Provider Relations Team uses in-person meetings, emails, and phone calls to communicate plan updates, revised

contractual requirements, policy changes, and other pertinent information to our network providers throughout the year. The Provider Relations Team consists of Provider Relations representatives, a Practice Innovation Advisor, Quality Improvement Advisors, and Provider Claims Educators. Other functions, such as Community Health Workers and Provider Contracting Representatives, also support the Provider Relations Team's efforts.

Provider Relations Representatives

Our Provider Relations representatives lead onsite visits with PCPs and high-volume specialist fields such as OB/GYN, cardiology, orthopedic, urology, adult day care, and respite care **at least quarterly**. Objectives of these site visits include:

- Review the provider's current patient roster and office visits
- Discuss targeted strategies to improve HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores, which includes education on Compass
- Address recent inpatient and high emergency department (ED) utilization
- Assess areas of improvement for clinical, value-based, claims, and other related documentation
- Evaluate current office initiatives and opportunities for partnership with Humana, such as telehealth
- As we engage providers in VBP arrangements, these visits will also include discussions regarding financial performance
- Deliver information to help the provider understand their overall performance metrics and ascertain whether their associates have any questions or training needs

We also use these visits as a mechanism to hand-deliver important communications and publications that may previously have been mailed or posted to our provider website. Provider Relations representatives share the following quarterly reports and data with PCPs and high-volume specialists:

- Performance profile and report card: Provides a snapshot of hospital admission rates, average length of stay, and ED visit rates
- New enrollment reports: Lists all new Enrollees from their panel
- Top Enrollees: Identifies Enrollees with highest incurred costs
- Top Rx: Identifies frequently prescribed drugs and evaluates any opportunities for generic equivalencies
- HEDIS reports: Includes identification of care gaps
- Emergency Department trends: Identifies Enrollees who have had repetitive and excessive ED visits
- Delivery system reports: Provides a list of efficient, in-network specialists available for Enrollees
- Newsletters: Publications that summarize topics vital to provider practices
- Mailings: Various communications we may have mailed to their office and reinforce during visits

We understand and respect the busy schedules of providers and are committed to ensuring the needs of both our providers and Enrollees are met. **Monthly, our Provider Relations representatives follow up with PCPs and high-volume specialists telephonically or via email, depending on the provider's preferred method of contact**. Provider Relations representatives cover the same topics listed above, as well as any other issues or concerns the provider would like to discuss.

On occasion, meeting at a location other than the provider's practice may be more convenient or appropriate. Humana has 25 local offices throughout Kentucky, which can serve as a meeting place for providers and Humana associates to discuss questions, needs, and concerns. Regardless of the meeting place, our associates are committed to providing the personal assistance and attention that providers desire.

As necessary, Provider Relations representatives will enlist other members of the Provider Relations Team, such as the Practice Innovation Advisor, Quality Improvement Advisor, or Provider Claims Educator, to use their areas of expertise depending on the provider's specific needs.

Practice Innovation Advisor

As a specialist on our Provider Relations Team, the Practice Innovation Advisor works with providers to develop strategies to refer Enrollees into care programs and educate on screening

and treatment for BH in a physical health setting (and vice versa), including the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach. They also support providers with data analysis, skill building, and other technical support to help them succeed in their value-based arrangements and are available to advise providers on how to apply the Practice Transformation Incentive in their practices. Additionally, the Practice Innovation Advisor offers statewide workshops in Patient-Centered Medical Home (PCMH) accreditation, **including at least one held in the first year of the Contract**.

Quality Improvement Advisors (QIA)
In conjunction with Provider Relations representatives, QIAs work collaboratively with providers to guide practice-specific strategies to improve quality performance. QIAs meet with our PCPs and high-volume specialists **at least quarterly** to deliver provider and Enrollee-specific metrics, such as actionable care gap reports and HEDIS measures. QIAs assist providers and their staff in integrating BH and physical health as well as in addressing Social Determinants of Health (SDOH) needs using our proprietary Community Resources Directory (CRD).

Provider Claims Educators
Provider Claims Educators are fully integrated with Humana's claim processing and provider relations systems to facilitate the exchange of information between these systems and providers. The Provider Claims Educator assists providers with all aspects of claims submission including coding updates, electronic claims transactions, electronic funds transfer (EFT), and available MCO resources, including our secure provider portal, Availity, self-service claim and code edit tools.

Community Health Workers
Our CHWs can visit providers and help educate them on resources that are available in the community to address Enrollee needs. More specifically, CHWs liaise among Humana Care Managers, providers, and Community-Based Organizations (CBO) to coordinate referrals for Enrollees to community-based services and programs and to foster integrated efforts among all parties. CHWs also facilitate engagement between Enrollees and their PCP and encourage the completion of health promotion activities, including (but not limited to) HEDIS gaps in care.

Provider Contracting Representatives
Provider Contracting Representatives execute and oversee all contractual relationships with our providers. These representatives work with providers to collaborate on initiatives in areas, such as telehealth, as well as support them in signing onto VBP agreements. They visit their assigned provider offices periodically to review contractual obligations, including medical records standards, and to review and discuss any updates to our relationship and programmatic obligations. They will visit more frequently if any contractual issues arise. The Provider Relations Team also provides feedback and input received from providers to Provider Contracting Representatives, ensuring that all parties are aware of current concerns and challenges facing a practice.

MECHANISMS TO TRACK INTERACTIONS WITH PROVIDERS

Humana stores information related to provider interactions in our enterprise data warehouse (EDW). From this repository, we can track distinct provider interactions across all platforms and route it to the appropriate team.

Electronic Interactions: We interact electronically with our providers in numerous ways. Providers may use Availity to submit claims, including through our clearinghouse, access education and training modules, and use our self-service tools to test claims. We track each of these interactions, noting which providers access the site and which tools they use. Providers also use our additional web-based tools, such as online training modules, which we track to ensure that providers can efficiently access the information we post. **Between January 1, 2019 and December 31, 2019, providers across the country made more than 592,300,000 transactions in our provider portal, Availity**, including more than 7,850,000 transactions made by Kentucky providers.

Physical Interactions: We log and track provider visits by our Provider Relations Team in Compass. The documentation field includes specific topics discussed and provider action plans to aid providers with Enrollee

health management. We also upload any documents pertinent to the PCP contact in this field. Our Provider Services Manager frequently reviews this tool, as each interaction with a provider, whether administrative or clinical, drives future interactions. If the Provider Services Manager sees negative trends in our reports, or if we receive negative feedback, we arrange for a more in-depth training session with our Provider Relations representatives. For example, if a provider is below the county average on HEDIS scores, the Provider Services Manager engages our QIAs and Provider Relations representatives to provide detailed training on HEDIS quality performance.

Telephonic Interactions: Our Provider Call Center Representatives (PCCR) log the topic and outcome of the call, routing and escalating (if needed) through our proprietary Customer Relationship Management (CRM) tool to the appropriate associate for resolution. We identify, track, and trend for root cause analysis to resolve concerns. We record the full interaction in our CRM for reporting purposes, including response resolution time.

Our Provider Network Director, Provider Services Manager, Provider Services Leader, Provider Advisory Committee, and Provider 360 Committee review all reports related to electronic, physical, and telephonic interactions to identify broader training needs. This could include training needed around a specific code edit or programmatic change, as well as targeted training on topics specific to a provider type or geographic area.

a.ii. Description of formal committees, workgroups, or other forums, if any, in which Providers can receive updates and instruction from the Vendor and offer input about the overall program and Vendor initiatives.

Face-to-face interaction with the provider community fosters strong provider relationships, which help us proactively address issues and concerns with our large provider network. In addition to regular meetings with designated Provider Relations representatives, Humana uses the following forums to ensure providers have an environment to freely voice their input on Humana-specific initiatives as well as the overall Kentucky MMC program:

Provider Advisory Committee (PAC): Humana will implement a PAC, including a BH Subcommittee, to help guide our provider communication and education strategy. Co-chaired by our Kentucky Medicaid Medical Director, Dr. Lisa Galloway, and Kentucky Medicaid BH Director, Liz Stearman, Certified Social Worker (CSW), our PAC will comprise diverse provider types and community leaders, such as a representative from State-operated or contracted psychiatric hospitals. The PAC will give providers a forum to speak openly and share feedback about Humana, our operations, and the Kentucky MMC program. We will also use the PAC as an opportunity to share updates and information with providers. In our other Medicaid markets, the PAC is a crucial component of our education strategy, informing delivery model decisions. The BH Subcommittee advises Humana on our approach to the integration of BH and physical health services.

Regional Provider Seminars: During our pre-go live period or instances of programmatic changes, we will conduct provider seminars in each Medicaid service region. During these seminars, we will discuss topics such as contracting/credentialing, care management, quality, BH, pharmacy, provider resources, and collaboration opportunities.

Provider Association Meetings: Humana currently participates in meetings held by the Kentucky Primary Care Association (KPCA) as well as the Kentucky Hospital Association (KHA). These meetings allow associates of our Provider Relations Team to engage with providers and stakeholders on issues that are not always voiced in forums with larger and more diverse audiences. Our regular attendance has helped bolster our relationships with participating members of these associations.

Technical Advisory Committee (TAC) Meetings: Humana will continue to support and participate in all TAC meetings. We are committed to ensuring our organization is updated and provides insight on issues affecting all stakeholders within the Kentucky MMC program.

Webinars: Humana offers interactive webinars throughout the year on topics such as claims processing, encounter submissions, continuity of care, quality improvement, serving dual eligible Enrollees, referrals and authorizations, credentialing processes, administrative documentation, as well as guidance regarding the Kentucky MMC Contract, and procedural guidelines. We identify topics for our webinars based upon requests from providers and input from our Provider Relations representatives and Provider 360 Committee.

Town Halls: During our recent implementation of a new Medicaid Contract in Florida, we held town halls in each region to solicit provider feedback and deliver provider education. **We will conduct similar town halls in the Commonwealth by hosting events in each service region during implementation and following significant programmatic changes**.

Provider 360 Committee Feedback: Our Provider 360 Committee is a cross-functional team chaired by Humana's Provider Services Leader. The Committee meets monthly to review provider trends related to claims, use of Availity, quality metrics, grievances, and other provider inquiries. The Committee is comprised of representatives from our Claims, Grievances and Appeals, Credentialing, Provider Relations, and Utilization Management (UM) departments.

Newsletters: Humana's ***YourPractice*** newsletter is a quarterly publication for providers and their office staff. It includes topics such as policy changes, quality information, and other relevant updates. We disseminate newsletters via email and make them available on both the Humana provider website and Availity.

Provider Portal: Availity, our provider portal, hosts education and training programs, including training on Humana processes, accredited courses on clinical best practices, and BH integration in primary care. Recorded web-based trainings and webinars are available 24 hours a day, seven days a week. Instructor-led training is also available at least once a week. Providers can read our newsletters and give feedback through an embedded satisfaction survey.

Humana's award-winning Strategic Provider Communications team coordinates the delivery of communications, such as newsletters and Provider Manuals. This team received the **2017 Stevie Award for Communications Department of the Year** and the **2017 OpenText Elite Award for Health Insurance Innovation**.

Proposed Initiatives

The forums described above have proven to be effective in keeping providers informed, as well as for providing spaces to gather provider input and feedback. Humana is always interested in exploring new and innovative ways to keep in touch with providers and collect their insights. Upon Contract award, Humana will collaborate with our community, provider, and other MCO partners to implement the following initiatives:

Community Advisory Boards: Based on feedback we have received from our provider and Enrollee advisory groups, we propose to organize regional community advisory boards (CAB) to serve as the eyes and ears of the community – charged with identifying gaps in services, areas of opportunity, and convening on a regular basis to create solutions for issues our Enrollees and providers encounter. These CABs will be attended by local non-profits, CBOs, providers, Enrollees, advocacy organizations, and others. The regional CABs will roll up to the statewide CAB and would feed into Humana's quality and governance processes to identify internal operational improvements. The Community Engagement team will work hand-in-hand with CHWs and SDOH coordinators in that region to recruit Enrollees, organizations, and providers to the CAB.

Joint MCO Forums: We also propose a collaboration with other contracted MCOs to hold quarterly forums with the provider community. MCOs would share in creating an agenda for each meeting, which would cover topics related to general MCO functions, as well as provider concerns. These forums would allow MCOs and providers

to work together to address concerns and bolster our relationships to further the goals of the general Kentucky MMC program.

a.iii. Methods and metrics used to collect provider feedback and to measure overall provider satisfaction, including frequency of doing so.

We continually measure provider satisfaction using multiple channels to identify opportunities for improvement. These efforts measure metrics as broad as providers' likelihood to recommend Humana to a colleague and as narrow as satisfaction with our PCCRs' ability to assist with claims-related questions. Our Provider Services Manager collects provider feedback received in the market and presents it at Provider 360 Committee meetings, which are held monthly. Our Provider Relations Team and market leaders review data to inform new initiatives addressing provider concerns or dissatisfaction. We describe our provider feedback channels below.

Provider Satisfaction Surveys: Our local market teams conduct **annual provider satisfaction surveys** in accordance with contractual obligations and department-approved sample methodology and metrics. The survey measures satisfaction across the following: provider relations and communication; clinical management processes; authorization processes including grievances and appeals, timeliness of claims payment, and assistance with claims processing; the complaint resolution process; and care management support. Our Provider Relations Team helps facilitate the dissemination of the surveys. We evaluate the survey results to identify specific areas to improve our providers' experience and to develop targeted training and education curricula. **We will implement two waves of provider surveys to create added opportunities to identify and address providers' "pain points" and attend to them expeditiously**.

Based on previous survey results, we have made several process improvements in order to improve provider satisfaction. These include:

- Improvements to Availity, including the addition of Claims Code Editor, which allow users to receive feedback in real time on claims submissions, edit claims, and file corrections
- Significant investment in the development of the tool Total Humana Overpayment Resolution (THOR) to reduce the need for provider recoveries by moving post-payment rules to prepayment edits, reducing the need to collect recoveries from providers
- Implemented a Provider Payment Integrity Unit Live Line for all providers as an additional channel to contact us regarding prepayment inquiries, edits, and reviews

Responding to Provider Feedback – Gold Carding

As a result of our overall provider satisfaction survey analyses, in early 2020 we are beginning to pilot a Gold Carding program for our Florida Medicaid providers. This program waives PA requirements for providers who have consistently exceeded PA performance and quality criteria. Humana plans to expand this Gold Carding pilot program to Commonwealth providers, tailoring it to their specific needs.

Office of the Chief Medical Officer (OCMO) Surveys: Our OCMO conducts annual **national surveys to measure satisfaction**. These telephonic surveys include questions asking providers whether they would recommend Humana to their colleagues and other providers. The OCMO conducts a similar survey of provider practices' office managers. The OCMO recommends opportunities for improvement across all lines of business and provider types.

Voice of the Customer Surveys: In March 2019, we re-engineered our post-call survey process to improve the diversity of provider responses (e.g., provider size, specialty) and response rates. These surveys are **automatically launched after calls** with our Issue Resolution Team, part of our Cost Claims Management department. They measure providers' likelihood to recommend Humana to a friend or colleague, associates' ability to assist the provider, ease of communication, and overall call experience. These surveys have led to

several process improvements, including, for example, the development of a timely filing calculator for call center associates. This calculator:

- Helps them calculate the timely filing limit for the provider
- Advises them whether a claim denied for timely filing was the appropriate outcome
- Or helps them determine if a claim was denied in error and needs to be re-reviewed

Provider Grievances and Appeals: We actively measure and trend our provider grievances and appeals to identify areas of improvement. Our data analytics tool, Clarabridge, allows for natural language analysis of provider concerns in real time to identify trends. We produce **several monthly** dashboard reports that identify trends that allow the Provider Resolution team managers and Provider 360 Committee to conduct root cause analysis and recommend opportunities for improvement.

Utilization Data: Humana has established a logic-driven process to monitor, identify, and respond to utilization patterns. Our data system platforms proactively monitor for over-utilization of certain services and identify any outliers in the data that may indicate a utilization or quality of care issue. Our UM Committee produces **quarterly** Provider Utilization Profiling reports, which use claims and encounter data to analyze under- and over-utilization as well as to provide peer-to-peer analysis. Utilization data analysis allows us to determine training needs regarding improving care delivery and cost efficiencies. **Monthly**, our Quality Improvement Committee (QIC) uses these reports to identify and prioritize training needs. Trainings are then coordinated and conducted by our Provider Relations representatives or via our online tools. We also note trends in inappropriate utilization and dispatch our medical management coordinator, BH coordinator, and/or Medical Director to provide direct one-on-one training.

Stakeholder Meetings: Humana currently participates in a number of local stakeholder meetings, including meetings held by the KPCA and KHA. These sessions are excellent venues for collecting feedback from providers and learning about their concerns. For example, common topics at the monthly KHA meeting include claims issues, credentialing challenges, and grievances and appeals. Attendees at the KHA meetings include KHA senior leadership, representatives from hospitals who are members of KHA, and Michelle Weikel, our Kentucky Provider Services Manager.

Humana also participates in Technical Advisory Committees (TAC) hosted by the Advisory Council for Medical Assistance. There are several diverse TACs, such as the BH TAC and the Primary Care TAC, each offering valuable opportunities to interact with providers of different specialties and backgrounds. Through these meetings, relationships are strengthened and providers have the opportunity to share feedback and concerns with Humana representatives.

a.iv. Methods the Vendor will use to minimize provider complaints and escalations to the Department.

Humana has a well-established “no wrong door” policy that allows providers to submit complaints easily in multiple ways (e.g., through their Provider Relations representatives, by mail, email, our website, or calling the Provider Services Call Center). Our Provider Resolution team is dedicated to addressing issues accurately and expeditiously. The team includes associates with specific areas of expertise (such as claims payment appeals) and tracks and researches all complaints using CRM and our proprietary inventory management system to ensure we comply with all contractual and regulatory requirements concerning resolution.

We engage in an extensive and active monitoring and oversight process to ensure that provider concerns are resolved timely and conduct root cause analysis to identify trends. Our cross-functional Provider 360 Committee’s goal is to improve our relationships with our providers continuously. The Provider 360 Committee meets monthly to discuss and analyze trend data, perform root cause analysis, and identify potential process improvements. The Committee then refers the issue to the Program and Project Management Implementation and Process Improvement team for rapid-cycle prioritization and assignment to a project team to research the

issue and report back to the Committee with findings and recommendations. The Provider 360 Committee may also escalate opportunities for improvement to the Local Market Operating Committee (LMOC), which consists of local senior leaders for analysis, resolution, and resource allocation when appropriate. The Provider 360 Committee's actions and recommendations are completely transparent to allow for active stakeholder engagement.

Recent Provider 360 Committee actions and recommendations include:

- We enhanced Availity capabilities by allowing providers to test claims for inaccuracies and potential rejections prior to final submission. Providers can also use Availity's claim status tool for real-time status updates.
- Our VBP program is structured to enhance collaboration with providers on aligned Enrollee outcomes as well as complaints and grievances related to claims

Additionally, Humana currently participates in meetings held by KPCA as well as KHA. These meetings allow our associates to engage with providers and stakeholders and discuss a variety of issues and concerns. Our regular attendance has helped bolster our relationships with participating members of these associations and has provided valuable insight into Kentucky providers' most pressing concerns and challenges. This feedback informs our efforts to help providers resolve concerns and challenges quickly and efficiently.

Finally, we recommend DMS consider establishing a workgroup with participation from all MCOs that examines the benefits and disadvantages of aligning its procedures with those of other states that require providers to exhaust MCOs' internal complaints, grievances, and appeals systems prior to escalating disputes to the Department. We also believe there is an opportunity to improve the current required report (#41) to increase consistency across plans and provide DMS a transparent view into MCO operations. These changes would allow MCOs to remedy any issues cooperatively with providers prior to involving the Department, as well as enable the Department to focus its resources on issues that are difficult to resolve or that may be relevant across multiple MCOs.

b. Describe the Vendor's proposed Provider Services call center, including an overview of the following at a minimum:

Informed by more than 20 years of MMC experience, Humana has a proven provider-centric call center strategy that achieves operational efficiency, exceeds industry performance requirements, and delivers superior service. **Our Louisville-based Provider Services Call Center is staffed by representatives who know and have extensive experience working with the provider community**. We intentionally located our Provider Services Call Center within walking distance of Humana's corporate offices to ensure PCCRs are readily supported by our locally-based corporate associates.

We use data to inform decision-making on staffing and operational improvements to create and maintain a superior provider experience. Key components of our strategy include:

- Extensive PCCR training to address all inquiries and concerns
- Streamlined routing systems to ensure providers receive assistance after hours
- Integrated analytics to alert Provider Services Call Center leadership to changes in call volume
- Monthly Provider 360 Committee meetings and LMOC meetings to discuss trends in frequent callers and commonly reported issues for targeted provider outreach and individualized training

We have incorporated industry best practices into our Provider Services Call Center approach. We intend for our Kentucky call center to be Humana's national hub, serving as a model for our other call center operations, investing in state-of-the-art technology to develop best practices. This hub will be designed to support future growth and will be staffed by Kentucky residents, demonstrating our commitment to our community and local provider partners.

STAFF TRAINING

Our core training curriculum is developed by our National Education and Policy Development team, who works in consultation with leaders from our Provider Services Call Center, Provider Relations, and Provider Network teams. We regularly refresh the training curriculum to address issues identified through our performance metrics, program updates, and provider feedback. During the first phase of the eight-week curriculum, we use a combination of technology-based and in-person training, including demonstrations of common situations. In addition to the training topics displayed in **Table I.C.17-1**, PCCRs receive extensive training on claims interpretation, authorization requirements based on specific procedure codes, provider contract review, and provider relationships with Humana call handling.

Table I.C.17-1: Provider Call Center Representative (PCCR) Training Topics

Medicaid and Managed Care	Fraud, Waste, and Abuse	Provider Credentialing
Kentucky Medicaid Managed Care Program	Legal Requirements (Privacy, Medical Necessity, etc.)	Claims (submission, status, and resolution), Billing Codes
Covered Services, Non-Capitated Services, & Value-Added Services	Support Systems, Community Resource Navigation	Online Resources, Availity (provider portal)
Behavioral Health Services, Behavioral Health Crisis Line, Harm Identification	Call Handling Etiquette, Warm Transfers, Escalations	Reporting Abuse, Neglect, or Exploitation (ANE), Restraint and Seclusion Prohibitions
Cultural Competency	Emergency Pharmacy Supplies	Care Management
Grievances, Appeals, Fair Hearings	Authorizations, Fee Schedules, Cost Sharing	Medical Records Standards and Other Administrative Requirements

For the final phase of training, PCCRs take mock phone calls followed by live calls while paired with an experienced trainer or PCCR. We monitor at least 10 calls per month for all new PCCRs and gradually reduce to five calls per PCCR per month. Managers assign additional training to address knowledge gaps related to contractual or programmatic requirements, opportunities for improvements in communication, or call etiquette observed during these calls. We require all PCCRs to be re-trained annually or more frequently, as needed, to address changes in operations, programs, or performance.

Trainees **must score at least 85%** on all content-specific examinations during the training and must pass mock calls to take live calls independently to maintain employment.

ROUTING OF CALLS TO ENSURE TIMELY AND APPROPRIATE RESPONSE TO INQUIRIES

Live Call Routing and Escalations: We train our PCCRs to resolve provider inquiries during the first call whenever possible. Using our Knowledge Management System, Mentor, PCCRs have access to information on key topics including claims history, status, payment, authorized services, and more, to aid in first call resolution. For calls requiring escalation, our Provider Services Call Center team includes a Provider Claims Resolution team and Provider Complaints team comprised of experts to resolve claims and complaints immediately. Calls concerning grievances or appeals are simultaneously entered into CRM, which then triggers an automated notification to our Provider Resolution team, who acknowledges and resolves the grievance or appeal. If a provider calls the Provider Services Call Center regarding clinical reviews or recoupments, we will warm transfer them to our Provider Payment Integrity hotline for assistance. Providers wishing to report a suspected case of fraud, waste, and abuse (FWA) are transferred to our Special Investigations Unit (SIU) so that an investigator can assist them. If the provider prefers, our PCCR will also

Humana was the first health plan to offer a conversational virtual agent to assist our network providers in answering their inquiries.

accept tips on FWA information and communicate it to SIU or transfer the provider to our anonymous hotline. We track call information in CRM, and our Provider Services Call Center Lead, Jenny Ludack, monitors to ensure appropriate follow up occurs. All callbacks are logged in CRM and tracked using the CRM comments, as well as included in our monthly Provider Services Call Center reports.

Inbound Call Interactive Voice Response (IVR) Routing: Our IVR system has been designed to route providers to the correct PCCR, including the ability to connect immediately with a PCCR. Our prompts include self-service options to verify enrollment, eligibility for certain services, PAs, and status of claims submitted. A provider can exit the self-service options at any time by asking to speak to a PCCR. Our IVR is integrated with our CRM to 1) ensure the IVR interaction with the provider is captured for our PCCRs to review, including a transcript of provider interaction, and 2) automatically identify providers calling from a phone number registered in our system. Following provider identification, the IVR asks providers to select the subject area for their inquiry, including benefits, eligibility, claims, PA requests, and the Enrollee about whom they are calling. **Attachment I.C.17.b-1** provides a flowchart of our IVR system.

CRISIS AND EMERGENT CALLS, WARM TRANSFERS, ESCALATIONS, AND PRIOR AUTHORIZATIONS

Our PCCRs use CRM and our technology platform to ensure a timely, accurate response to provider inquiries (e.g., enrollment verification). Specifically, (a) we warm transfer providers calling about a BH crisis to our 24 hours a day, seven days a week BH Crisis Line and to our Medical advice line if the provider requests clinical assistance, (b) if PCCRs require assistance to provide resolution in a timely manner, they are trained to escalate the call and have immediate access to their supervisor or Clinical support, and (c) we do not require providers to submit authorizations for emergency services prior to accessing the services. Our Provider Network team trains providers to refer all Enrollees in crisis or with an emergent condition to the ED.

To decrease administrative burden and improve provider experience, Humana has reduced the number of BH services requiring PAs to only five outpatient services.

PRIVACY PROTOCOLS, INCLUDING HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Humana has strong privacy and security protocols in place across our organization. We follow all federal and State laws and regulations, including 42 C.F.R Parts 160 and 164. We assess our protocols at least annually and update them more frequently if the need arises. Humana offers a third-party, 24 hours a day, seven days a week toll-free hotline to allow for anonymous reporting for anyone who suspects a privacy or security breach. Depending on the type of violation, our Chief Compliance Officer, Sean O'Reilly, or our Kentucky Medicaid Chief Compliance Officer, Kimberly Myers, works with the appropriate associates to resolve suspected violations.

b.i. Approach to assuring the call center is fully staffed during required timeframes.

Humana has a proven workforce management strategy that achieves operational efficiency, exceeds industry performance requirements, and delivers superior service. Through forecasting of provider interaction volume based on historical data, our dynamic staffing model is adjusted at least monthly to account for emerging trends (e.g., outreach campaigns) and to support effective scheduling of PCCRs. We will adjust our current staffing model to fit the Department's requirements and recognized call volume in Kentucky. We will maintain a minimum ratio of one PCCR for every 3,750 Enrollees and will re-evaluate this ratio regularly.

As a data-driven organization, Humana uses performance and process metrics to continuously evaluate staffing to ensure high-quality interactions with providers. The goal of Humana's Workforce Management team is to create an environment that provides timely Enrollee engagement, optimized workforce utilization, and high employee satisfaction. From the science of forecasting, to the logistics of capacity planning, to the

personalization of scheduling, to urgency of intraday management, we strive to promote a culture that maintains a keen focus on the interaction and engagement between providers and our associates.

We use Aspect Workforce Management as our platform to forecast future call arrival and staffing requirements. Aspect Workforce Management provides a foundation for effective forecasting, staff planning, shift scheduling, and daily management. Our Workforce Management team, leaders, and supervisors use Aspect Workforce Management to proactively manage key performance indicators throughout each day.

Hours of Operations

In accordance with Section 27.2 of the Draft Medicaid Contract, our Provider Services Call Center will be staffed Monday through Friday 8 A.M. to 6 P.M. Eastern Standard Time (EST), including federal holidays. We also offer self-service options to our providers through our IVR and Availity, both of which are available on demand, 24 hours per day, seven days a week. During non-business hours, providers may also access our Clinical Intake Team (CIT) for authorization requests.

Providers may request authorizations 24 hours a day, seven days a week.

After-Hours

We have several options available for providers during non-business hours to ensure their various needs are met in a timely and effective manner.

- Our IVR supplies information about our hours of operation and lists self-service options, including enrollment verification for Enrollees presenting with urgent conditions during non-business hours. Providers may also use our IVR system to obtain answers about eligibility, claims submission, and authorizations.
- All providers have access to our Utilization Review Accreditation Commission (URAC)-accredited Medical advice line 24 hours a day, seven days a week, to verify enrollment for an Enrollee presenting with an urgent condition
- Providers have after-hours access to Availity to submit authorization requests and access Enrollees enrollment information, claims status, and authorizations

Forecasting

The Workforce Management team gathers relevant data points to build forecast models specific to our Provider Services Call Center operational needs. Utilizing Aspect Workforce Management, regression techniques, and time series forecasting approaches, our forecast analysts study contact volume, average handle time, attrition, and other locally specific metrics to generate long-term and short-term forecasts. Using these forecasts, our leaders execute staffing plans in conjunction with training leaders to generate weekly schedules for associates. Using these tools, leaders are able to get an hour-by-hour and day-by-day view of each associate's schedule to quickly adjust when necessary. On a more granular level, these forecast and scheduling data are updated and analyzed daily to ensure proactive adjustments are made to optimize short-term efficiency, as well as provide a continuous improvement feedback loop for future forecasts.

Staffing

We take a data-driven, iterative approach to analyzing trends and inputs to execute staffing plans that flex to the evolving requirements of each day and week. Utilizing outputs from our forecasting process, such as leading and lagging indicators across productivity, accuracy, and key performance indicators, the Workforce Management team develops staffing plans to address daily, weekly, and monthly forecasts. Our leaders and supervisors monitor and act to improve operational efficiency continuously, adjusting assignments and schedules as necessary. We maintain a variety of shift schedules based on the hours of operation and distribution of workload to guide us toward specific types of schedules (full-time, part-time, flex, 10-hour, preference-based, etc.) that most efficiently support staffing models.

Intraday Management
Our Workforce Management team is located in the Provider Services Call Center to manage all scheduling and daily management activities. The Workforce Management team monitors the real-time status of associates and their expected activity. Daily meetings are held where our Provider Services Call Center leaders meet to proactively review projected performance for the following three weeks, drive optimal performance, and plan for any short-term staffing or volume impacts. Throughout the course of each day, forecast and scheduling data are updated and analyzed on an interval basis to ensure that proactive adjustments are made to staffing to optimize efficiency based on daily call delivery trends. We use electronic, up-to-the minute display boards so that leaders and call center associates have a visual status update of call center queues at all times.

High Volume Support
Associates in our other state Medicaid call centers are cross-trained to support our Provider Services Call Center during emergencies. Medicaid providers rarely, if ever, experience busy signals or downtime. Even during times of system stress, such as weather-related disasters, our back-up call centers and nationwide resources ensure we have associates available as an essential component of our business continuity and Disaster Recovery Plan.

Oversight and Management
This model for monitoring staffing levels builds in multiple stages of oversight, ensuring we exceed Commonwealth and internal call center performance expectations. Humana uses data-driven analyses to continuously evaluate our Provider Services Call Center staffing ratios to reduce the time it takes for providers to receive the assistance they require. Our Workforce and Productivity team, along with our Kentucky-based leadership team, monitors call center statistics to manage staffing levels based on performance measured against DMS standards and best practices. We use real-time business intelligence reports in our Avaya Call Center Manager function (including call center metrics and agent productivity) to make immediate tactical adjustments.

Between December 1, 2019 and January 15, 2020, Humana's Kentucky Medicaid Provider Services Call Center **consistently answered 97.60% of calls within 30 seconds**, exceeding the service level standard. Additionally, **our Average Speed of Answer during this timeframe averaged 4 seconds**.

b.ii. Location of proposed operations.

Providers are best supported by those who live in their communities and understand the unique local needs and challenges. For example, PCPs, such as Brock Medical in LaRue County, have very different needs and concerns from large providers such as Norton Healthcare. **In order to ensure that our associates can be closer to the communities we serve, all Humana Provider Services Call Center associates are located in Louisville, Kentucky**. We also believe that collaboration across our departments can enhance efficiencies for both our providers and Enrollees; therefore, our Provider Services Call Center is co-located with our other Kentucky Medicaid teams, including our Member Services Call Center, Provider Services, and claims processing teams. These teams are also within walking distance of Humana's corporate resources and leadership, providing additional channels of direct support and collaboration.

b.iii. How the Vendor will meet and monitor call center standards, and how the Vendor will use monitoring results to adjust operations, as needed.

Our Provider Services Call Center tracks all required DMS metrics, such as average speed of answer (ASA), call abandonment rate, blocked call rate, average hold time, and timely and accurate responses to call center inquiries. We also vigilantly assess any potential call volume influxes and adjust our staffing appropriately to ensure provider satisfaction, as well as timely and quality care for our Enrollees.

We consistently exceed call center performance standards for the Kentucky MMC program. Between December 1, 2019 and January 15, 2020, **our call abandonment rate was 0.51%, far below the requirement of under 5%**.

MONITORING SYSTEM TO TRACK METRICS

Ensuring adequate staffing levels: As described in sub-question I.C.17.b.i of this response**,** our Workforce and Productivity team and Kentucky-based leadership meets weekly to proactively review projected performance for the following three weeks. This allows us to adjust our staffing and avoid negative provider or Enrollee experiences.

End-of-call surveys: A key part of our operational strategy is to review continually provider satisfaction with our call center associates. We currently conduct automated post-call surveys for all inbound calls. With six simple questions, we review the provider's experience with their PCCR and overall inquiry resolution, including the option to leave an explanation for their rating. The results of these surveys are reported at our Provider 360 Committee meetings and our LMOCs, which meet monthly to identify opportunities for process improvements and system enhancements.

ONGOING PERFORMANCE EVALUATION

We evaluate at least five calls per PCCR per month to assess accuracy and timeliness of responses.

Our data-driven performance evaluation includes first call resolution, blocked call rate, busy signals, queue and average hold times, average speed of answer (where "answer" is defined by reaching a live voice, not reaching an IVR), call abandonment rates, timely responses to call center inquiries, and accurate responses. We use IBM Watson as an Artificial Intelligence (AI) tool to analyze calls and callers' satisfaction levels with the calls. Finally, we review calls that could not be resolved during the provider's initial outreach to the call center to determine whether the PCCR handled the call appropriately, communicated the need for additional research, and explained the expected timeframe for resolution clearly and effectively. Call Center managers will assign additional training to address knowledge gaps related to contractual or programmatic requirements or opportunities for improvements in communication or call etiquette noted during these calls. We also ensure that the necessary follow up occurred within that timeframe.

Our cross-functional Provider 360 Committee also actively monitors Provider Services Call Center performance. This Committee's primary objective is to have a 360-degree view of the Medicaid provider experience with Humana, with the goal of continuously identifying ways to improve our provider relationships. Chaired by our Provider Services Leader, Mary Sanders, the Committee includes market leadership and a combination of market and corporate support areas, including our Kentucky CCO, Kimberly Myers, Provider Services staff led by Michelle Weikel and Majid Ghavami, and our Claims Performance Management, Integrated Provider Solutions, and Provider Communications organizations. The Provider 360 Committee meets monthly to discuss and analyze data trends, perform root cause analysis, and identify potential process improvements.

ADJUSTING OPERATIONS AS NEEDED

To maintain the high-quality provider support for which Humana is known, we will continually modify Provider Services Call Center operations to address issues related to our metrics and providers' experience through the following mechanisms:

- Hiring additional staff to ensure sufficient staffing ratios
- Modifying IVR routing to adhere to Contractual and programmatic requirements and performance expectations
- Assigning targeted training to our call center associates to improve provider and Enrollee satisfaction

c.	Provide an overview of the Vendor's proposed provider website, including examples of information that will be provided through the website and any functionality that will be included to communicate with providers. Provide sample screenshots of provider websites currently maintained by the Vendor.

Providers can easily access Humana and DMS Medicaid provider materials and our provider portal, Availity, through our dedicated provider website, Humana.com/provider. We use data to drive our decision-making as it relates to Enrollee care, enhanced provider experience, and process improvements. As such, we measure and track how often the website and portal is accessed. We perform monthly updates to ensure it remains a valuable avenue through which providers can access and submit pertinent information related to our Enrollees, processes, and the Kentucky MMC program. **Between January 1, 2019 and December 31, 2019, providers across the country made more than 592,300,000 transactions in our provider portal, Availity**, including more than 7,850,000 transactions made by Kentucky providers.

Provider Website

The Humana provider website allows providers to access Medicaid materials easily and hosts our secure provider portal, Availity. We update our website monthly to ensure it serves as a convenient resource to engage and educate providers. We prominently display urgent updates (e.g., State of Emergency notices) and information about quality initiatives for our providers (e.g., annual checkups or breast cancer screenings). In accordance with Section 27.3 of the Draft Medicaid Contract, our website will include the following information:

- Our searchable Provider Manual and Provider Directory
- Humana's PA requirements
- Kentucky's Medicaid Preferred Drug List (PDL) and pharmacy conditions for coverage and utilization limits
- Enrollee rights and responsibilities
- Information regarding the KHIE
- Links to other websites, such as Cabinet for Health and Family Services (CHFS) and DMS. Once the Department selects its CVO(s), we will provide the link(s) to their website

In 2018, **99% of our Florida Medicaid providers** surveyed found that our provider websites (Availity.com and Humana.com/provider) are easy to use and provide useful information on determining eligibility. **100% of providers** found our provider websites housed useful information on determining coverage and benefits.

Provider Portal

Availity, our provider portal, optimizes information exchange between multiple channels via a single, secure network. Through Availity, we continuously share and receive Enrollee and practice-level data, such as claims, care gaps, and financial performance as it relates to value-based arrangements, to and from our providers. Our custom portal hosts education and training programs, including training on Humana processes, accredited courses on clinical best practices, and BH integration in primary care. Recorded web-based trainings and webinars are available 24 hours a day, seven days a week and instructor-led training is available at least once a week. Providers can also test claims and edit claims submissions, manage PAs, read our newsletters, and give feedback through an embedded satisfaction survey. Providers may also submit grievances and appeals with supporting documentation through our portal in encrypted format.

Humana is committed to providing seamless data-sharing capabilities to our network. Our Provider Relations representatives have visited multiple provider offices to elicit feedback and recommendations on how we can best improve and enhance our data-sharing platforms.

See **Exhibit I.C.17-1**, **Exhibit I.C.17-2**, and **Exhibit I.C.17-3** below for screenshots of our provider website. For additional screenshots and a more comprehensive view, please see **Attachment I.C.17.c-1** for screenshots of our provider website, Humana.com/provider, and provider portal, Availity.

Exhibit I.C.17-1

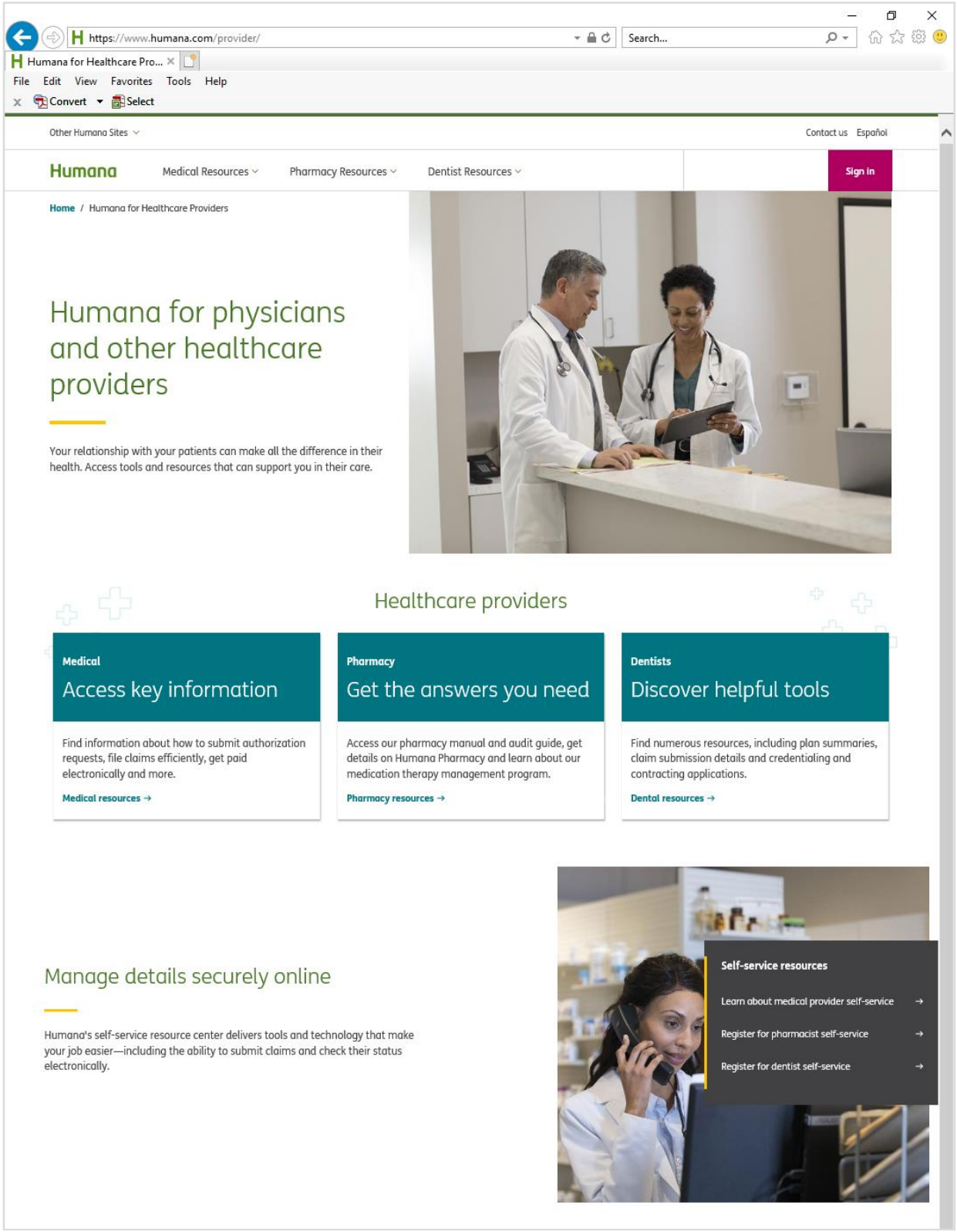


Exhibit I.C.17-2

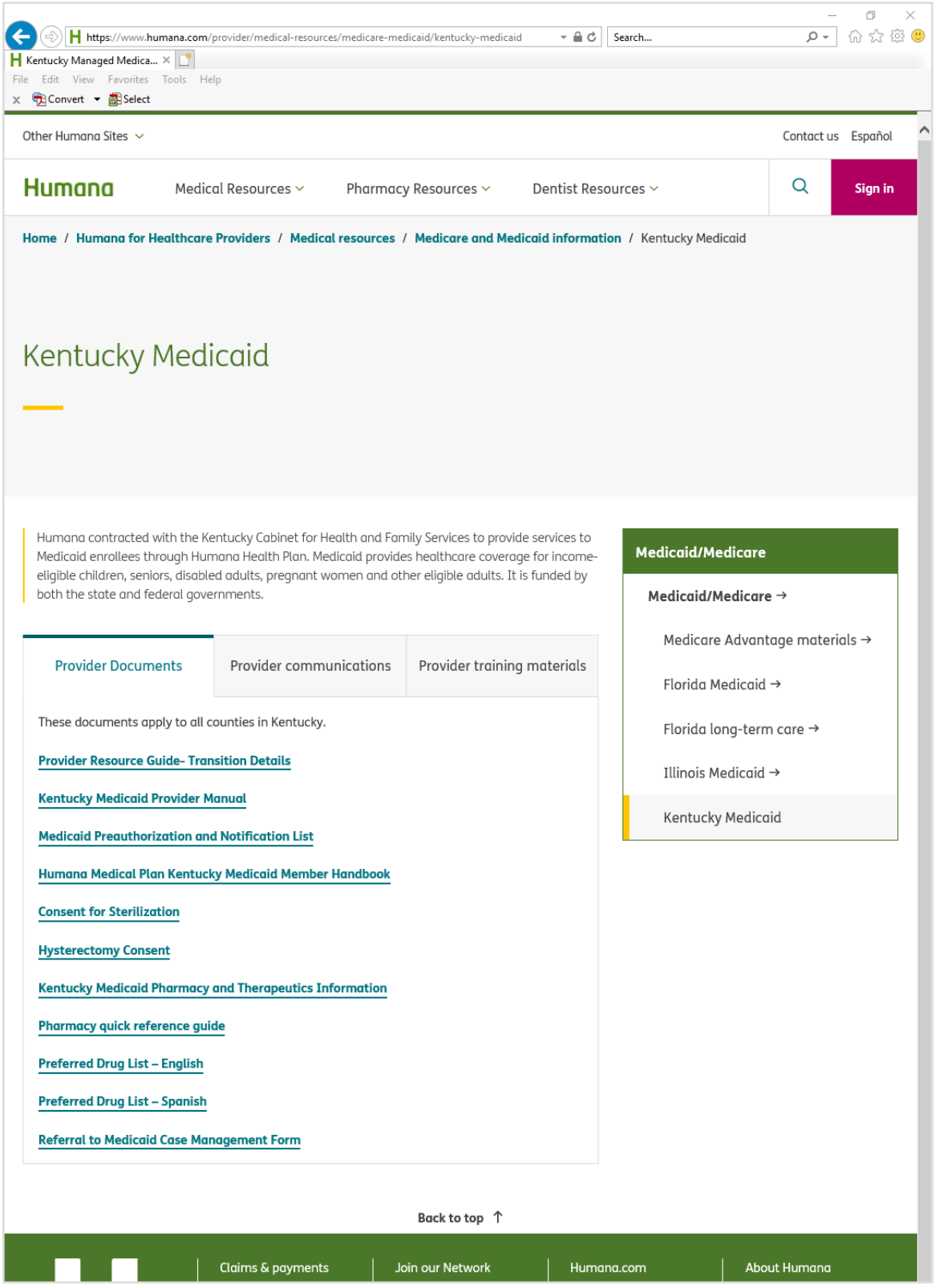
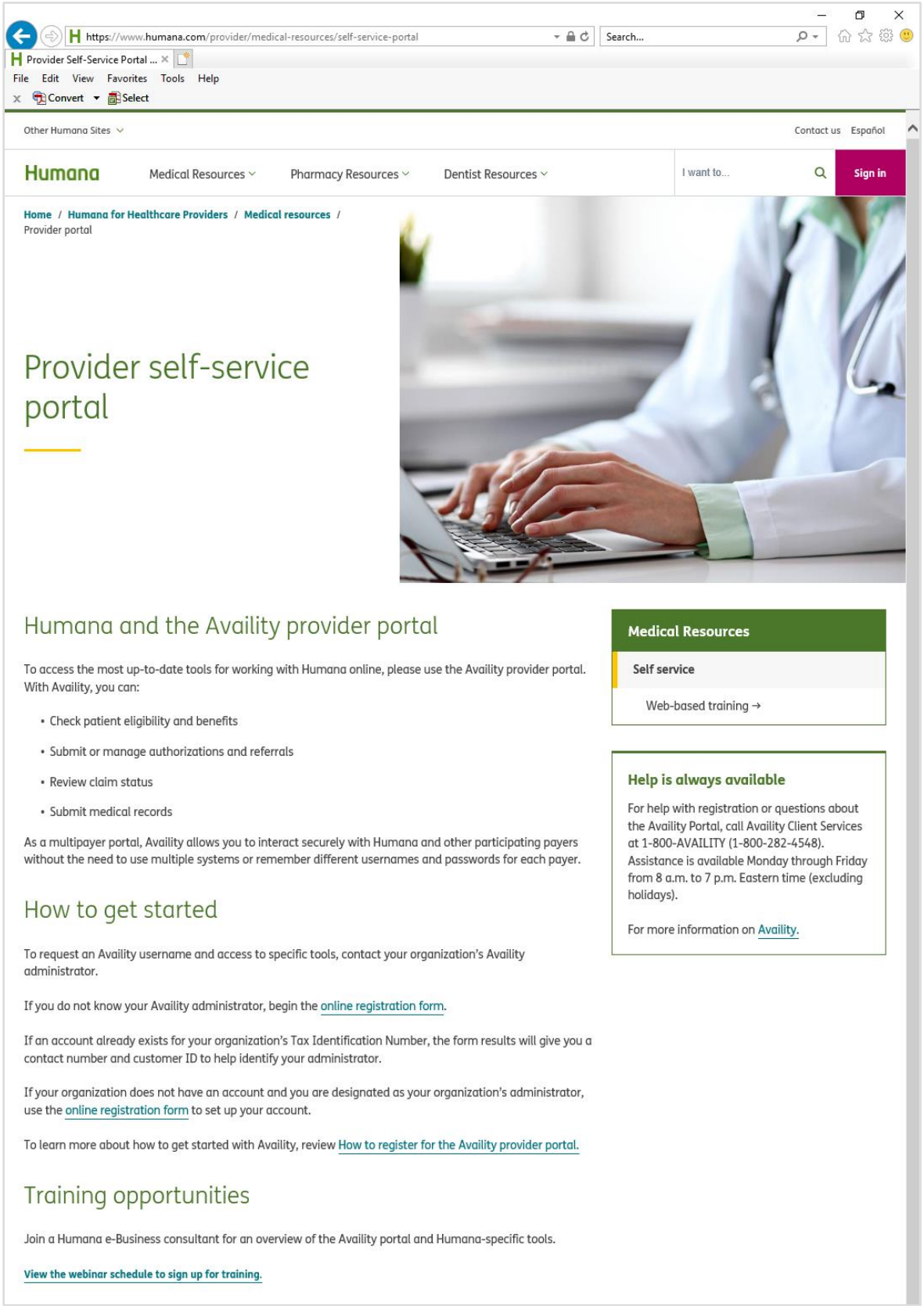


Exhibit I.C.17-3



d. Provide a proposed table of contents for the Provider Manual and a brief description of the type of information the Vendor will communicate via the manual.

Humana distributes a hard copy (upon request) of our Provider Manual to providers within a maximum of five days following enrollment into the network and annually thereafter, upon request. The Provider Manual is also available online for electronic access at any time. Updated annually, the Provider Manual serves as a primary and thorough source of contractual requirements and general provider policies and procedures. Additionally, it serves as a tool to inform providers and their staff on what to expect when interacting and doing business with Humana. Our Provider Relations representatives also use this tool to help educate our providers during the orientation process.

Our Provider Manual complies with all Kentucky MMC program contractual requirements and thoroughly describes how to communicate with Humana, Enrollee enrollment and eligibility information, Enrollee benefits, cultural humility, care management, Covered Services, referrals and PAs, claims submission, grievances and appeals, provider roles and responsibilities, quality improvement, program integrity, FWA, and credentialing. Please see **Attachment I.C.17.d-1** for Humana's proposed Provider Manual table of contents. Also, please see **Attachment I.C.17.d-2** for a copy of Humana's current Kentucky Provider Manual.

Included in our proposed Provider Manual will be a **Spotlight Section that highlights policies, procedures, and tools unique to BH provider needs**. For example, BH providers often need well-defined, tailored information about Enrollee privacy. They also require additional details about coordination with PCPs and CMs and mental health parity regulations.

e. Provide the Vendor's proposed approach to provider orientation and education.

Humana's comprehensive provider training programs are structured to be flexible and scalable to support our providers' varying knowledge bases, needs, and learning styles. We offer a variety of training formats to ensure that information is accessible and convenient, such as web-based trainings, conference-style, and one-on-one trainings. The training formats used include face-to-face orientation, monthly meetings, Humana's Provider Manual, materials available on our website and Availity, quarterly provider newsletters, and ongoing support available from our Provider Relations representatives. We implement our education and trainings in three phases: 1) initial training or onboarding, 2) required annual training, and 3) a tailored education program.

INITIAL PROVIDER TRAINING PROGRAM (ORIENTATION)

We use a cross-functional, integrated, and high-touch approach to support and train providers. This approach begins once a provider is contracted and credentialed. Within 30 days of their contract effective date, all providers new to Humana's network receive orientation training from their assigned Provider Relations representative, who will also serve as their point of contact for all future trainings. This training is an opportunity for providers to understand Humana operations and processes, provider roles and responsibilities, and the vast resources available to them. We conduct the initial orientation in the provider's office, which includes information on all necessary and contractually required topics to help guarantee a mutually successful partnership. Orientation topics include:

- Introduction to the Kentucky MMC program
- Contracting and credentialing
- Access to care requirements
- Web resources
- PA and notification process
- Claims processing and claims resolution process
- Continuity of care
- Enrollee special needs consideration
- Enrollee screening and needs for alcohol and substance abuse
- Clinical management programs
- PCMH
- Medicaid risk adjustment

- Medicaid Advisory Panel
- Service level agreements
- DMS provider-based guidelines
- Annual compliance trainings
- Grievances and appeals
- Cultural competency
- Health, Safety, and Welfare (HSW)
- FWA and Business Ethics
- OB/GYN training (for OB/GYNs only)
- Critical incident reporting
- Disenrollment or transfer of an Enrollee
- Helpful numbers and region-specific Quick Reference Guides
- Kentucky Medicaid Provider Handbook
- BH toolkit for PCPs
- Electronic health records
- Kentucky Health Information Exchange
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) preventive health screening and special services
- Telehealth services
- Population Health Management program
- Quality Improvement initiatives
- VBP
- Medical records review
- SDOH

In 2018, we conducted provider orientation training for approximately 1,400 providers in the Commonwealth. Beginning in 2019, we track PCP orientation trainings using the Provider Relationship Manager tool within Compass. We use provider feedback to continually modify and improve our provider training content, materials, and delivery sources. **Attachment I.C.17.e-1** provides a copy of our Kentucky Medicaid provider orientation training deck. Additionally, see **Attachment I.C.17.e-2** for a sample provider orientation checklist.

REQUIRED ANNUAL TRAINING

Humana's provider training program is ongoing, and we are continuously educating our providers on new information that promotes the success of our Enrollees' overall health, as well as the Kentucky MMC program. Throughout the year, we send multiple reminders to providers through email, fax, and phone calls using multiple communication mechanisms to ensure providers' compliance with our required annual training. Our annual training includes:

- Programmatic updates
- Refresher training on topics, such as claims submissions, cultural humility and competency, and program integrity, including FWA
- Specialized topics, such as billing and service authorization requirements
- Training for BH providers on contractual and programmatic requirements

To promote maximum attendance and convenience for our providers, training is available through self-directed, online programs. Training includes a wide range of topics, such as integrated care, including appropriate utilization of basic BH screenings in the primary care setting and basic physical health screenings in the BH setting, utilization of medication-assisted treatment (MAT) to treat Opioid Use Disorder, accessing PDLs on our websites, pharmacy claims processing, and payment policies and procedures. We require targeted training by our Provider Relations representatives that addresses BH topics, including how to access our comprehensive e-Library to support physical health and BH integration. Cultural competency is a training priority for us; we require all network providers to complete this training annually. The training also includes topics such as health, safety, and welfare; FWA; our Code of Conduct; and Business Ethics.

Providers receive information about our training materials during the in-person orientation with their assigned Provider Relations representative. Our Provider Manual also describes available trainings and how to access them. Providers and their office staff can access training modules online 24 hours a day, seven days a week on both Humana.com and Availity. Our Provider Education e-Learning Library also allows providers to continually revisit and/or take trainings pertinent to their practice. We also use Brainshark, a program that creates five to 10-minute computer-based training (CBT) modules, to streamline annual training requirements. Each module is followed by a quiz to demonstrate competency and if necessary, includes a link to a more comprehensive version. The CBT modules allow us to embed reference material, as well as a mandatory survey used to capture

provider completion data. We track completion of all providers' trainings, both electronic and in person. Provider Relations representatives follow up with providers who do not complete training; failure to adhere to training requirements may result in termination from our network.

TAILORED PROVIDER EDUCATION PROGRAM

Our provider education strategy is designed to address providers' varying knowledge base and practice needs in a flexible and engaging manner, ensuring that information is both accessible and convenient. We continuously enhance our provider education program, adjusting to changing programmatic requirements and provider feedback. We incorporate Medicaid-specific education, including the topics described in Section 27.5 of the Draft Medicaid Contract.

We recognize that provider education is not a static process and that we need to reach providers in different ways, at different times, and through different delivery methods. We use four simultaneous avenues of educational training to ensure we support our providers in delivering the best care to our Enrollees, which include 1) face-to-face education, 2) web-based individual training, 3) webinars, and 4) on-demand training.

Face-to-Face Education

Providers are assigned a Provider Relations representative who serves as their point of contact for all training. We seek to schedule these training sessions at the provider's convenience, at a time when there is minimal patient care activity and provider attendance is optimal. We may conduct one-on-one trainings in providers' offices or at a Humana location. Conference-style, Service Region-based trainings are held in a central location (e.g., hotel conference room or Chamber of Commerce facility). We welcome and encourage DMS representatives to attend any education seminars we conduct.

Web-based Individual Training

Humana provides supplemental, web-based training through Availity. Recorded web-based trainings may be taken anywhere and are available 24 hours a day, seven days a week. Through Availity, providers and their associates may access training related to:

- Claims management
- Authorizations management
- Electronic Remittance Advice (ERA) and EFT management
- Clinical Solutions
- Electronic Data Interchange (EDI)
- Eligibility and Benefits Inquiry
- Patient Responsibility Estimator Tools
- Payment Collection and Processing
- 5010 Overview
- Annual Compliance training
- Humana Orientation
- Cultural Competency
- Health, Safety, and Welfare
- FWA and Business Ethics
- Trauma-informed care (TIC) and Adverse Childhood Experiences (ACE)

Webinars

Humana continuously offers interactive webinars throughout the year. The subject matter of these webinars is determined by requests from providers, trends observed by our Provider Relations team, and system or programmatic changes.

Available Resources and On-Demand Training

In addition to face-to-face training, webinars, and web-based training, Humana offers resources and on-demand training described in our Provider Manual and provided through our provider website, quick reference guides, service fund trainings, and self-guided modules. Humana also sends out quarterly provider newsletters, as well as email blasts containing important information on policy changes, quality, industry changes, and medical protocols. Examples of recent newsletters are included in **Attachment I.C.17.e-3**.

f. Describe the Vendor's support of providers in Medicaid enrollment and credentialing, including the following:

Humana has designed our credentialing and re-credentialing processes to ensure our network of contracted providers are qualified to deliver high-quality care to Enrollees. All Humana-contracted providers complete a thorough initial credentialing and ongoing re-credentialing process. Since 2013, Humana has completed credentialing for 11,551 providers and re-credentialed 8,106 providers in Kentucky across all lines of business. This includes credentialing 7,433 providers and re-credentialing 5,538 providers in our Medicaid line of business. From July 2019 through December 2019, our average credentialing time for Kentucky Medicaid providers was seven days for physicians and 1.4 days for facility/ancillary providers. Over that same time period, 97% of physicians and 98% of facilities were re-credentialed on time. Additionally, our load time is a maximum of 10 days for physicians and 15 days for facility/ancillary providers. Our success in provider credentialing and load process is a combination of both our dedicated and knowledgeable credentialing staff and Humana's proprietary workflow management tool, the Accelerated Provider Exchange (APEX).

APEX automates and accelerates the credentialing, provider load, and provider demographic update processes. It also allows Humana associates throughout the company to communicate with providers regarding their credentialing and network participation status in real time and with full transparency throughout the process. Humana is also implementing an improved provider information verification process to ensure we have updated provider demographic and participation status information available to our Enrollees, enhancing their access to care. We recognize that process efficiency and communication of provider participation status are critical to ensure provider engagement and satisfaction. Our experience and processes detailed below describe how these efficiencies can make it easier and quicker for providers to become credentialed. This is particularly true when the full CVO process is implemented and operational.

f.i. Methods for assisting providers who are not enrolled in Medicaid with the enrollment process.

Humana has established policies and procedures to assist providers who are interested in becoming a Kentucky Medicaid Provider, pursuant to the requirements outlined in 907 KAR 1:672. See **Attachment I.C.17.f-1** for our full process documentation for assisting providers in Kentucky Medicaid enrollment. Since 2013, we have helped more than 1,600 providers navigate the enrollment application process for obtaining a Kentucky Medicaid provider identification (ID) number.

We identify providers to assist through several channels:

1. We monitor claims activity for providers who are getting rejections due to non-registered or non-active IDs; when identified, we reach out to them and offer assistance
2. As we work through Letters of Agreement to bring out-of-network providers in-network, we proactively offer and provide assistance to providers who have not enrolled in Medicaid
3. Providers contact our Credentialing Team directly and ask for assistance with the Medicaid enrollment process
4. Our Kentucky Provider Services staff identify providers through their regular interactions with providers across other lines of business, as well as when they meet new providers in the community. Enrollee-specific needs are also considered as the Provider Services team meets and identifies possible Medicaid providers; upon identification, the Provider Services team refers the provider to our Credentialing Team
5. During the credentialing or re-credentialing process, we confirm the provider has an active Medicaid provider ID number using the Kentucky Medicaid Master Provider List (MPL); if they do not have an active Kentucky Medicaid Provider ID number, Humana's Credentialing Team will provide assistance

In all cases, our Credentialing Team carefully tracks the list of providers whom we are assisting and will follow up with them to facilitate the process. Once the Credentialing Team receives the name and contact information of a provider in need of assistance, the Credentialing Team reaches out and assists the provider with completing the MAP-811 enrollment application. Humana collects the application and verifies the information and submitted documentation against the provider type summaries. Humana will then submit the application and supporting documentation on behalf of the provider to the State through the Medicaid Partner Portal Application (MPPA) system for the Commonwealth to review and determine enrollment eligibility. The Kentucky Medicaid Provider Enrollment office will notify the applicant of the decision.

Under exceptional circumstances for emergency services, as described in 907 KAR 1:672 section 2(8)(a), Humana will collect the traditional MAP-811 and supporting documents from the provider. Humana will contact the Kentucky Medicaid Provider Enrollment staff directly to expedite processing of the enrollment application.

> **"Humana's assistance with the enrollment of our providers in the Kentucky Department of Medicaid Services has significantly improved the timeliness and efficiency of the process. This collaboration gives our credentialing team the assurance the participation approval will be followed through until completion, enabling our providers to effectively treat and manage the care of Kentucky Medicaid members much sooner."**
>
> – Crystal Hardacre
> Chief Payor Relations Officer
> The Christ Hospital Health Network

f.ii. Proposed process for conduct of credentialing until such time that a Credentialing Verification Organization (CVO) is contracted by the Department.

Humana has stringent, documented credentialing and re-credentialing policies and procedures in place, designed to reflect the highest level of credentialing requirements among all governing agencies – including the requirements of the Kentucky Draft Medicaid Contract, federal requirements, and NCQA guidelines. Humana currently conducts all credentialing and re-credentialing processes internally without the use of an external entity; however, Humana will comply with any new credentialing requirements, including but not limited to, streamlined credentialing processes and working with a CVO. Our Credentials Committee exists to ensure that we adhere to the processes and procedures outlined and that we credential and re-credential providers within the set requirements. The Committee, which Humana's Medical Director chairs, includes representation from a range of participating providers in both primary care and specialty disciplines.

Credentialing is one of the quality assurance components the National Committee for Quality Assurance (NCQA) regularly assesses in awarding Humana's Kentucky Medicaid plan accreditation. **Humana has earned 100% of the available points on all NCQA renewal surveys**.

PROCESS TO CONDUCT CREDENTIALING

Humana requires credentialing for providers included in the provider directory. Humana will continue to use existing processes for contracting, credentialing, re-credentialing, and loading providers until a CVO is contracted by the Department. Humana's credentialing process requires all providers to submit the following information to initiate credentialing:

- Education and Training: Provider has completed appropriate education and training for applied specialty
- State License: Provider holds a current Commonwealth professional license, certificate, or registration in the State(s) in which they will treat Humana Enrollees

- Drug Enforcement Administration (DEA) and/or Controlled Dangerous Substances (CDS) Certificate, Eligibility for Medicaid: Provider holds a current Federal DEA certificate and/or a CDS certificate, if applicable to profession
- Professional Liability Insurance (PLI): Provider holds current PLI at or above our minimum required amounts, has completed the PLI exception procedure, or has documentation of coverage under the Federal Tort Claims Act for professional liability coverage
- Claims History: Provider has acceptable liability claims history. Any history of repeated catastrophic claims which, after examination by the Credentials Committee and/or the Medical/Dental Director, indicates a propensity for or trend in malpractice claims, and/or are unusual for a provider in that specialty, is grounds for denial. The provider can satisfy the Credentials Committee by showing that such actions do not indicate a continuing quality of care concern.
- Work History: Provider demonstrates appropriate history of employment and clinical practice. Provider should explain any gaps in work history greater than six months and should satisfy the Credentials Committee that such gaps do not indicate a continuing quality of care concern.
- Facility Privileges: Provider holds current clinical privileges in good standing at a participating facility, if applicable to profession. Clinical privileges should not contain any material limitations.
- Federal, State, and Local Sanction Free Status: Provider holds current sanction-free status by federal, State, and local authorities to supply healthcare services, unless provider satisfies the Credentials Committee that such sanction does not present a continuing quality of care concern
- Medicaid Terminated and Excluded Provider List Verification: Provider must show proof that they, as well as any existing employee or contractor, have not been terminated or excluded from participation in the Kentucky MMC program or nationally excluded from Medicaid or Medicare
- Prior Actions or Relinquishments: Provider should not have a history of any action in effect within the last five years taken by a federal, State, or local government, including, but not limited, to the applicable State licensing body; by a hospital, health plan, or other healthcare entity; or by a professional society; or any suspensions or other restrictions that include material limitations. Within the last five years, the provider should not have voluntarily relinquished any membership, license, privileges, or participation status or other ability to render healthcare services, including a State license or clinical privileges. Such prior actions or relinquishments may not be grounds for denial if the provider satisfies the Credentials Committee that such action or relinquishment does not indicate a continuing quality of care concern.
- Convictions: Provider has not been convicted of, nor has pleaded guilty or no contest to, (a) any felony, or (b) any misdemeanor involving moral turpitude or related to the practice of a healthcare profession, the Federal Health Program fraud and abuse, third-party reimbursement, or controlled substances, unless the provider satisfies the Credentials Committee that the conviction or plea does not present a continuing quality of care concern
- Physical or Mental Impairment: Provider should not demonstrate a physical or mental impairment, including impairments from chemical dependency, which may impair their ability to practice or pose a risk of harm to patients

Individual practitioners, which includes provider types such as PCPs; OB/GYNs; and specialists (such as osteopaths, podiatrists, pulmonologists, cardiologists, and all others) are required to supply the following information, in addition to the requirements listed above.

- Completed Kentucky Application for Provider Evaluation and Re-evaluation (KAPER) form or completed Council for Affordable Quality Healthcare Inc.'s (CAQH) application: Provider must supply a completed application and attest to the completeness of the application. Attestation signature date must be current within 180 days.
- Kentucky Medicaid provider ID number: Provider demonstrates current eligibility for participation in Medicaid, as applicable, and is enrolled with a Kentucky Medicaid provider ID number

- National Provider Identifier (NPI) and taxonomy: Provider has a NPI and taxonomy that is assigned and verifiable through the National Plan and Provider Enumeration System (NPPES)
- Disclosure of Ownership: When completing enrollment documentation for providers, we collect disclosure of ownership forms related to ownership and management, business transactions, and conviction of crimes for providers whom Humana completes enrollment
- Confirm Languages: National Network Operations and Credentialing Operations will confirm languages that the providers use, including American Sign Language (ASL)
- Performance Standards: For re-credentialing, practitioners should demonstrate an acceptable performance record related to Humana Enrollees

Minimum credentialing and licensure are the same for facilities, including hospitals, as listed above for all providers. Facilities/hospitals are also required to submit:

- Completed Facility Credentialing Application, including attestation questionnaire and Kentucky Medicaid provider ID number
- Accreditation, or Medicare certification, or a copy of the CMS or Kentucky Office of the Inspector General (OIG) site review
- Clinical Laboratory Improvement Amendments (CLIA), as applicable
- Confirm NPI, taxonomy, and Disclosure of Ownership
- For re-credentialing only, practitioners should demonstrate an acceptable performance record related to Humana Enrollees

CREDENTIALING AND RE-CREDENTIALING APPLICATION PROCESS

Information about and assistance with the credentialing and re-credentialing process is available from Provider Relations representatives, the Provider Manual, the provider website, the Provider Services Call Center, provider orientation, and quick reference guides. Humana uses CAQH's Universal Credentialing ProView, which is an online service that helps physicians and other healthcare providers with the credentialing process, including State-specific credentialing applications as required by State regulations. Humana acts only upon complete credentialing and re-credentialing applications, defined as a submitted application form completed with responsive and accurate information, dated and signed, and accompanied by all required and requested documents. Upon receipt of a complete credentialing or re-credentialing application, a credentialing specialist loads the provider application into APEX. Currently, APEX includes a credentialing module that organizes supporting documentation, automates the process, and facilitates the credentialing specialist's review of the credentialing application for mandatory criteria.

Humana's APEX system contains links to various verification sources, which helps streamline and expedite the credentialing and re-credentialing verification process. For example, APEX receives a feed from the American Medical Association (AMA) that allows verification of credentialing information in real time. We also have links to the OIG verification source and the General Administration Sources verification source to review any sanctions against the provider. Additionally, we have built in an "attach a screenshot" feature in APEX as part of the credentialing and re-credentialing process. A credentialing specialist can capture a screenshot of a verification site, such as licensure verification, which becomes evidence of verification as part of the credentialing file. This advancement eliminates the need to print and upload the verification to our system, further expediting our credentialing process.

APEX records date of verification, verification source, and the report date as part of the credentialing and re-credentialing process. Humana also assigns each member of our credentialing staff a unique electronic identifier, which we record in APEX, as part of the credentialing quality assurance process.

Verification of credentialing information comes from one of the following sources:

- The primary source
- A contracted agent of the primary source

Another NCQA-accepted source for the credential documentation of verifications includes:

- Credentialing documents signed and dated by the verifier
- A detailed checklist, including the name of the source used, the date of verification, the signature or initials of the credentialing specialist who verified the information, and the report date, if applicable

CREDENTIALING AND RE-CREDENTIALING DECISION-MAKING PROCESS

Humana uses a tiered process for credentialing and re-credentialing approval, with categorization (Category I and Category II) determining the path for approval. This process allows the Credentials Committee to expedite credentialing approval or more thoughtfully consider an approval, if necessary, for Enrollee access.

For Category I credentialing applications, which meet all credentialing criteria, Humana's Medical or Dental Director approves these daily and presents them to the Credentials Committee during monthly meetings. The Credentials Committee has final approval or denial authority for credentialing and re-credentialing applications.

For Category II credentialing applications which do not meet all credentialing criteria, Humana's Medical or Dental Director presents applicants monthly to the Credentials Committee. The Committee comprises participating providers in both primary care and specialty disciplines who employ a peer review process to determine whether to approve or deny Category II applicants. We document meeting minutes as evidence of the Credentials Committee's discussion and decisions, certified by a chairperson or designee signature. Once credentialed, re-credentials are due every three years from initial approval date.

Humana processes the credentialing or re-credentialing decision of the Credentials Committee as follows:

- Approvals: The Credentials Committee notifies providers of the decision within 30 days for all provider types
- Denials: Humana notifies the provider of the reasons for the denial and provides notice of an opportunity to request reconsideration of the decision in writing within 30 days of notification. Upon reconsideration, the Credentials Committee affirms, modifies, or reverses its initial decision. Humana notifies the provider in writing of the Credentials Committee's reconsideration decision within 60 days.
- Adverse Actions: Adverse Actions are actions or recommendations that limit, reduce, restrict, suspend, revoke, terminate, deny, or fail to renew a provider's participation in Humana's Network for reasons related to quality, and that adversely affect, or could adversely affect, an Enrollee's health or welfare. Adverse Actions lasting longer than 30 days entitle the applicant to prompt notice of his or her right to request a hearing under the Humana Provider Quality Review Process.

PROVIDER OFFICE SITE EVALUATIONS

As part of the pre-credentialing process, Humana will survey PCPs' and OB/GYNs' office locations, as applicable, to confirm they meet our office site standards. During credentialing, Provider Relations representatives organize a site visit for applying providers to verify data, as listed below, that we collect on the application.

Humana's comprehensive provider site visit evaluation tool meets all federal, State, and Americans with Disabilities Act (ADA) compliance measures and is included as **Attachment I.C.17.f-2**. During this site visit, Humana verifies information including, but not limited to:

- ADA compliance
- Waiting and exam room cleanliness and accessibility
- Risk management (e.g., emergency procedures and safe disposal of identified chemicals)
- Ancillary services (e.g., CLIA certificates)
- Safety (e.g., signage)
- Access and availability (e.g., answering services, appointment scheduling)
- Medical record keeping and filing (e.g., security measures)
- Thresholds for acceptable performance against criteria

Humana verifies all items listed above during credentialing and then re-verifies every three years during re-credentialing. Regardless of site visit scores, any significant deficiency in any critical element will result in a site visit failure. We allow all site visit failures time to correct deficiencies and require a repeat site visit prior to submitting a provider's application for credentialing. Significant deficiency examples include:

- Non-compliance with ADA
- Inadequacy of medical/treatment record keeping
- Uncleanliness of waiting and exam room space

ONGOING MONITORING AND INTERVENTIONS

Humana monitors provider sanctions, complaints, and quality issues between re-credentialing cycles and ensures corrective actions are taken to address occurrences of poor quality. We implement ongoing monitoring and appropriate interventions, up to and including removal from the network, by collecting and reviewing the following information within 30 calendar days of its release:

- Medicare and Medicaid sanctions and exclusions
- Sanctions or limitations on licensure
- Complaints
- Identified Adverse Events

GATHERING DATA FOR RE-CREDENTIALING PROCESS

Humana re-credentials our providers at least every 36 months. Humana employs effective and structured mechanisms to collect provider performance information for the re-credentialing process. APEX automatically populates the provider performance score into the provider's file prior to the re-credentialing decision. Provider performance indicators include:

- Provider complaints
- Outlier prescriber/procedure history
- Grievances and appeals
- HEDIS scores
- Utilization

Humana's Quality Management System (QMS) electronically tracks providers with confirmed quality of care issues by NPI and interfaces with the APEX for a quality performance score.

DELEGATED AND SUBCONTRACTOR CREDENTIALING

Delegated and Subcontractor credentialing is the process by which Humana has agreed to allow qualified entities to perform a portion of our credentialing review process and oversees the delegate to ensure ongoing adherence to program requirements. Humana delegates credentialing and re-credentialing activities to organizations or entities that demonstrate compliance with federal, State, and accreditation requirements, such as NCQA. These activities include:

- Collection of application and attestation
- Primary source verification
- Site visits and medical record keeping review
- Ongoing monitoring of information
- Credentialing and re-credentialing decision making

Before Humana delegates the credentialing function to any entity, we perform a preauthorization performance capacity audit to evaluate compliance with Humana's standards, which includes compliance with federal, State, and NCQA accreditation. We review the following criteria during the audit:

- Credentialing policies and procedures
- Program descriptions and work plans
- Forms, tools, and reports
- Credentialing Committee minutes
- Sub-delegation agreements
- Letters of accreditation
- Credentialing file review

Humana measures results on a standard audit form that determines if we approve the entity for delegated credentialing.

- Entities with a score of 95% or above are approved
- Entities with a score between 70% and 94% (by section and total) may be approved with a corrective action plan (CAP) in place, which will include the identified issues and deficiencies, the corrective actions required, and the timeframes for performance of the corrective actions and achieved results
- If an entity scores below 70% during a pre-delegation review, Humana does not approve them for delegation

All delegated entities are subject to, at a minimum, an annual review to ensure they meet State, federal, and NCQA accreditation oversight requirements. Results of the annual audit are recorded on a standardized audit tool and then scored to determine the delegate's ability to meet compliance requirements according to the following compliance thresholds:

- Delegates with an annual audit score of 95% or higher may be approved without requiring a CAP, although potential opportunities for improvement should be documented and communicated to the delegate
- Delegates with an annual delegation audit score of 70-94% may only be approved if a CAP is implemented
- Delegates with an annual audit score below 70% must be referred to the appropriate committee, market leadership, compliance leadership, or business owner for additional evaluation and final determination on appropriate and necessary steps, which may include additional corrective measures, cancellation of a particular delegated function by termination of a delegation attachment, or termination of the delegation services addendum

Audit results are reported to the appropriate committee, market leadership, compliance leadership, or business owner, and Delegation Compliance will continue to monitor all delegated entities through the collection of periodic reporting.

In 2019, we issued CAPs to two delegated entities for non-compliance with Kentucky Medicaid credentialing requirements. All identified issues were subsequently resolved in a timely manner.

Humana executes a delegation agreement with all delegated or subcontracted entities. It outlines the responsibilities of both the plan and the delegated entity as well as the assessment and evaluation of the credentialing standards. Ongoing oversight ensures that the delegated entity continues to operate in a compliant manner.

f.iii. Proposed process for transitioning credentialing activities to and coordinating with the Department's contracted CVO(s) to educate and assist Providers in completing the credentialing process with the CVO(s).

Humana will work collaboratively with the contracted CVO and Department upon selection of the CVO. Humana's Provider Network Director, Majid Ghavami, will serve as a liaison to coordinate and oversee the relationship with the CVO to ensure we are addressing any concerns or issues that may arise during the implementation of streamlined credentialing.

Upon notification that the Department has contracted with a CVO, Humana will take inventory of our credentialing work in progress. Any provider whose credentialing packet has not yet begun undergoing the verification process will be transferred to the CVO via the agreed-upon secured method; the method depends on the CVO's available technologies. Humana will also begin referring providers to the CVO for credentialing and re-credentialing. We will complete credentialing any in-process providers and submit the completed credentialing packets to the CVO, in addition to a full listing of all previously credentialed providers and their re-credentialing dates.

Humana has invested in systems that will ease the transition to a CVO. For example, APEX will enable Humana to electronically exchange files with the CVO for data gathering and exchange. **Attachment I.C.17.f-3** illustrates our proposed process flow for coordinating credentialing activities with the CVO.

During this transition, Humana will meet with the Department and the CVO as often as necessary to ensure a smooth implementation and full transition to the CVO to include setup and full testing of all file and data exchange interfaces, tracking and reporting, and communications mechanisms.

EDUCATING AND ASSISTING PROVIDERS WITH THE CVO CREDENTIALING PROCESS

Humana implements a multi-prong approach to educate providers on the credentialing process. This process will be modified to include education about the CVO and overall credentialing process upon CVO selection. These methods are listed below:

- Personalized education during provider recruitment: During provider recruitment, Humana discusses the credentialing process with providers to ensure they understand the process, taking this opportunity to answer any questions. We also prompt providers to enroll in and update their CAQH application prior to initiating the credentialing process, which ensures their information is up-to-date. Provider Relations representatives also play a critical role during the re-credentialing process by communicating with providers about any required action to complete re-credentialing.
- Direct support during credentialing and re-credentialing: A Provider Relations representative will contact the provider by phone or email to obtain any missing information from the credentialing or re-credentialing application and answer any questions about the application to proactively prevent delays in the process
- Provider Manual: Humana's Provider Manual contains detailed information and answers to frequently asked questions about the credentialing and re-credentialing process. Our Provider Manual is available to providers both online and in hard copy (upon request).
- Provider Website: Humana's provider website has information available, 24 hours a day, seven days a week on the credentialing and re-credentialing process
- Provider Services Call Center: We train our call center associates to understand and explain the credentialing and re-credentialing processes
- Initial Provider Orientation: We supply training on the re-credentialing process during initial provider orientation
- Evaluation of the CVO Process across Product Lines: Humana is committed to evaluating a multi-product approach of the CVO process to ensure administrative and cost efficiencies are achieved for both providers as well as MCOs across all lines of business in which the provider participates

f.iv.	Approach for a timely contracting determination of providers upon receipt of information from a CVO that a provider's credentialing is complete, specifying timeframe for uploading a credentialed and contracted provider into the claims payment system to allow for payment of adjudicated claims. Include copies of the Vendor's proposed credentialing policies and procedures, and procedures for coordination with the CVO(s).

Since 2013, Humana has credentialed more than 11,000 providers in Kentucky. This deep experience has informed our streamlined process, which allows us to load contracted and credentialed providers into our systems within 10 days. Upon receipt of the completed credentialing packet from the CVO, Humana's Kentucky-based Credentialing associates will upload the provider's contract and credentialing information into APEX, where tasks are generated for the provider load, contract load, credentialing, Service Fund, our Provider Information Management System (PIMS), and our Claims Adjudication System (CAS). At this time, providers can be recognized, submit claims, be paid, and use all other Humana provider-related activities and tools. This process is supported by our Credentialing Committee, which meets monthly to discuss ways to improve the

provider experience through this process. Our Medical Director is also actively involved and reviews "clean" submissions daily, which helps facilitate faster turnaround times for loading providers into our system.

Please see **Attachment I.C.17.f-4** for Humana's proposed credentialing policies and procedures. Additionally, we have included our proposed policies and procedures as well as a flowchart for coordination with the CVO(s) in **Attachment I.C.17.f-5**.

g.	Provide the Vendor's proposed approach for processing provider grievances and appeals. Include at a minimum:

Humana has a robust process for resolving provider grievances and appeals. Our approach is based on a **no wrong door policy** that ensures all provider grievances and appeals are consistently processed and tracked no matter the avenue that we receive them (via phone, email, mail, fax, or web portal) and that we comply with all contractual and regulatory requirements concerning resolution. We view grievances and appeals as a critical source of information about the quality of our operations and provider satisfaction. Because grievances and appeals are a window into accurate and timely payment of claims, PA practices, and provider education and training, we include an oversight committee as a key component of our approach. Our provider-centric approach and strategy are designed to get ahead of grievances and appeals, thereby mitigating unnecessary provider concerns. Key components of our strategy to address provider grievances and appeals include:

- Training of call center associates, Provider Relations representatives, and Provider Resolution team associates to equip them with the knowledge and resources to address grievances on the spot
- Streamlined systems to log, track, and store all grievances- and appeals-related information
- Real-time analytics, including trended data, that alert Humana to issues within our provider network as well as with our claims processing and payment system
- A Kentucky-based, fully dedicated Enrollee and Provider Complaint, Grievance, and Appeal Coordinator, Andrea Williams
- Leadership recognition and ownership of our active Provider 360 Committee, which meets monthly to discuss provider grievances and appeals

Our provider grievances and appeals resolution process includes a specialized, highly trained team to ensure timely responses to grievances submitted directly to DMS, as well as monitoring of procedures and metrics to respond quickly to DMS' requests related to grievances and appeals resolution.

g.i.	The overall process to include description of interaction with providers, required correspondence and timeframes for acknowledging and resolving grievances and appeals.

DESCRIPTION OF THE OVERALL PROVIDER GRIEVANCES AND APPEALS PROCESS

We use multiple channels to educate providers about our grievances and appeals system and to interact with them as they navigate through it. Upon entry into our network, all providers must participate in a mandatory orientation that describes our grievances and appeals procedures. Provider Relations representatives and PCCRs in our Provider Services Call Center educate providers about the grievances and appeals process and can assist providers in filing a grievance or appeal. Providers may also access detailed information about these procedures in our Provider Manual, which is available to them in paper (upon request) and electronic formats. They may also access this information through our provider portal.

Reasons for Grievances and Appeals: Under our policies and procedures, provider grievances can encompass any expression of dissatisfaction including those related to our policies and procedures, authorization requirements, or operational concerns. Grievances may also include things such as rude behavior by our Subcontractors.

Providers may file appeals for issues such as denials of healthcare service, claims for reimbursement, provider payment, and contractual issues.

Provider Resolution team: The Provider Resolution team is responsible for researching and resolving provider grievances and appeals in compliance within required timeframes. The Provider Resolution team is comprised of highly trained and experienced associates with specific areas of expertise (e.g., claims review and payment, clinical authorizations, Contract requirements, etc.) to resolve grievances and appeals accurately and expeditiously.

Tracking Grievances and Appeals Timeframes: The Provider Resolution team logs grievances and appeals in our end-to-end tracking system built to process grievances and appeals consistently, within the Commonwealth-mandated timeframes, and in compliance with Kentucky statutes and regulations. Our inventory management tool, mhk, overlays our CRM and is a state-of-the-art tool to support resolution of grievances and appeals.

Our inventory management system records all grievances and appeals by the date the grievance or appeal was filed, type of issue, identification and contact of the provider, the name of the associate receiving the grievance or appeal, disposition, date of resolution, and any corrective action required. **Our systems are configured to comply with programmatic performance requirements, which allow us to track relevant deadlines, including all notifications, the 30-day timeframe for resolution of grievances and appeals, flag cases at risk, and adhere to programmatic obligations while compiling a full and complete record**. This enables our Provider Resolution associates to respond to providers with the information necessary to avoid future grievances and appeals. Our system's enhanced capabilities include regulatory compliance documentation functions, root cause analysis, and trend analysis tools and flags for critical issues, such as quality of care concerns.

RESOLVING PROVIDER GRIEVANCES

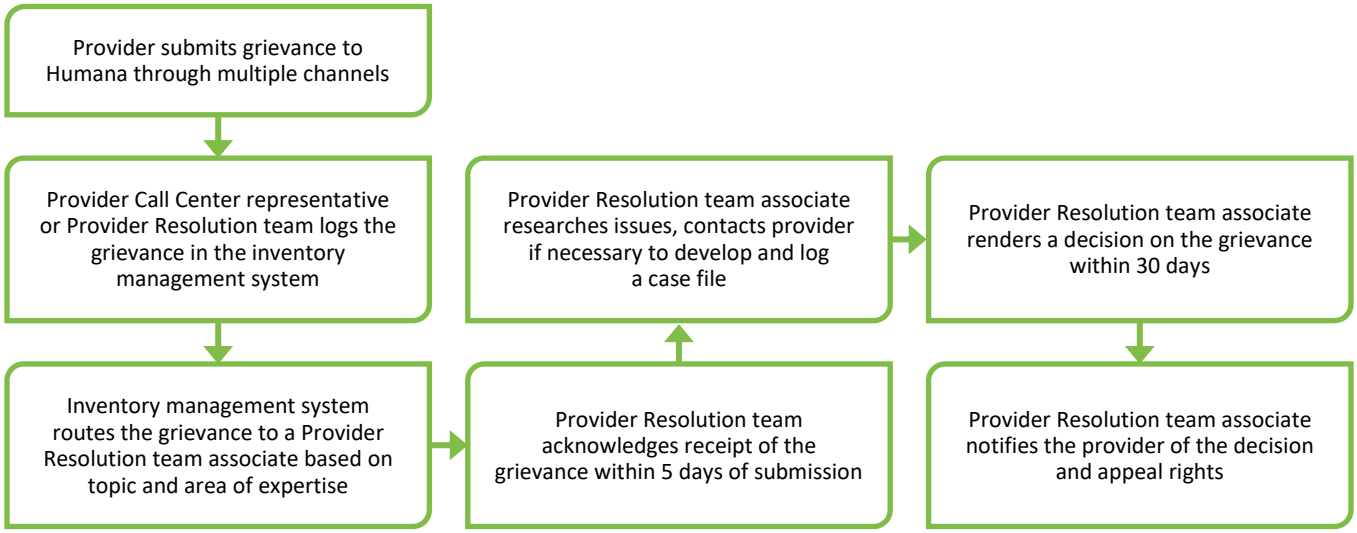
Once a provider submits a grievance through any of our available avenues, the associate receiving the grievance logs it in the inventory management system.

Within five business days of receipt of the grievance, the Provider Resolution team associate who was assigned the grievance notifies the provider in writing that the grievance has been received and will be resolved within 30 days. The written acknowledgement refers the provider to our Provider Services Call Center for questions.

The Provider Resolution team thoroughly researches each grievance, reaching out to the provider as necessary to obtain additional information. The Provider Resolutions team has service level agreements with our business partners to ensure timely response. For example, the Provider Resolution team collaborates with our Claims team, Claims Cost Management, and Provider Payment Integrity associates to research and resolve the grievance of a denied claim. Following their research, the Provider Resolution team associate decides how the grievance should be resolved in accordance with applicable statutory, regulatory, contractual, and provider agreement provisions.

Within 30 days, the Provider Resolution team associate completes their reviews and prepares a resolution letter informing the provider of the decision and notifying them of their right to appeal the decision. If the associate is unable to reach a resolution within 30 days, they will request an extension from the provider. The Provider Grievances process is summarized in **Figure I.C.17-2** below.

Figure I.C.17-2: Provider Grievances Process



RESOLVING PROVIDER APPEALS

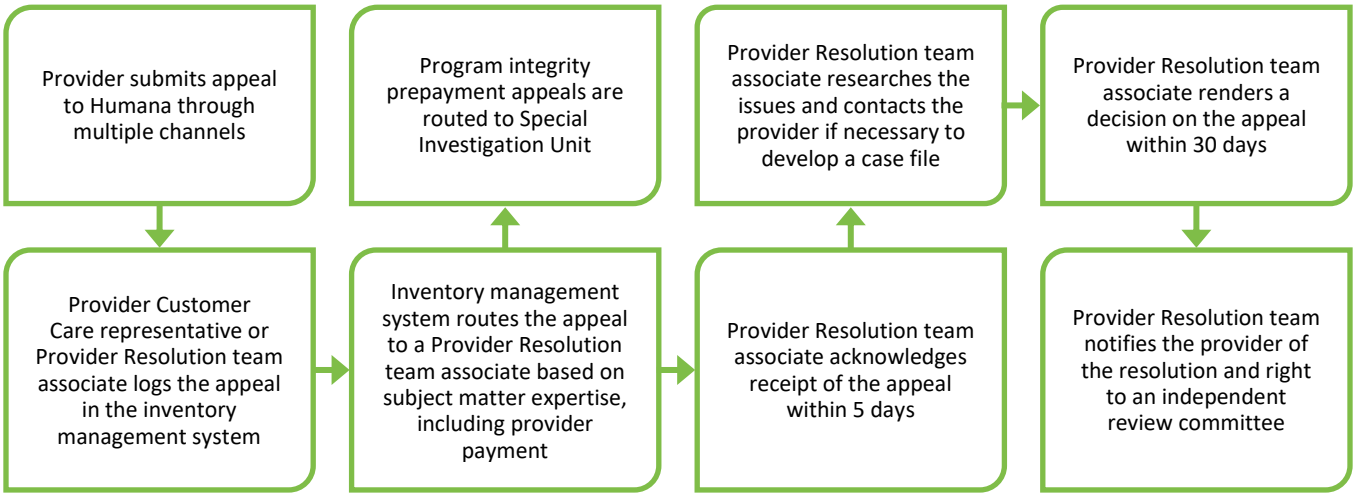
Under our policies and procedures, providers may file appeals for issues such as denials of healthcare services, claims, provider payment, or contractual issues. Providers may also appeal a decision by Humana to place the provider on prepayment review in accordance with Section 36.2 of the Draft Medicaid Contract.

As with a grievance, a provider may submit an appeal through multiple communication channels including via the Provider Services Call Center, letter, email, or Availity. Upon receipt of the appeal, the associate receiving the appeal logs it in the inventory management system, sending an acknowledgement letter to the provider within five days and informing the provider of the expected resolution date. The inventory management system automatically routes the appeal to an associate with relevant subject matter expertise. All appeals regarding prepayment review are routed to the SIU for review and resolution.

The Provider Resolution team associate assigned to the appeal assembles a case file, contacting the provider if necessary. The Provider Resolution team has the authority to make resolution decisions, including adjudication of claims. Upon resolution of the appeal, the Provider Resolution team associate notifies the provider of the resolution decision within 30 days and of the provider's right to an independent external review in accordance with **907 KAR 17:035** and **Section 27.10(E)** of the Draft Medicaid Contract.

Our Provider appeals processes are summarized below in and **Figure I.C.17-3**.

Figure I.C.17-3: Provider Appeals Process



INDEPENDENT REVIEWS

In accordance with **Section 27.1(E)** and **36.2** of the Draft Medicaid Contract, providers may request we assemble a committee of three or more qualified individuals who were not previously involved in a decision or action to review the appeal and render a new decision. Providers can also request an external third-party review following exhaustion of our internal procedures.

GRIEVANCES AND APPEALS RECEIVED FROM DMS

For provider grievances and appeals received by DMS and sent to Humana, our specially trained and highly qualified Critical Inquiry (CI) team, which consists of 18 full-time associates with a combined 190 total years of experience with an average of more than 10 years with Humana, uses a distinct and integrated fast-track process for these grievances and appeals. Our CI team is uniquely qualified for this role, drawing from internal associates with experience in Humana's operations, as well as strong investigative, analytic, and writing skills. We provide specialized training to all CI associates regarding the lines of business relevant to their substantive responsibilities and the provider grievance process, so they are familiar with every potential source of dispute. We also train CI associates on contractual requirements and compliance and provide retraining when there are changes to procedures or as needed based on internal reviews, Contract amendments, and new federal or Commonwealth regulations.

We log all grievances and appeals received by DMS in our tracking system, and cases are assigned to the CI team for handling. The CI team logs all inquiry notes and documents them in CRM where we can append all inquiry notes to any existing provider grievances and appeals in our reports. This process enables greater contextual awareness that allows us to track provider grievances and appeals more effectively through enhanced oversight and better-informed trended data. Upon receipt from DMS, we assign all provider grievances and appeals to a CI associate who will confirm receipt of the grievance or appeal to the provider and DMS, research the issue, and respond with the disposition to the provider and DMS. The CI associate complies with the same policies, procedures, and tracking systems as the Provider Resolution team. CI team data are included in our daily, weekly, and monthly performance and trend reports for oversight purposes.

REQUIRED CORRESPONDENCE AND TIMEFRAMES

Our systems are configured to automatically generate required correspondence within the timeframes for acknowledging and resolving grievances and appeals. Specifically, our inventory management system:

- Acknowledges grievances and appeals within five business days
- Ensures written notices of resolution are sent within the required timeframe of 30 days
- Includes information regarding next level appeal rights in correspondence with providers, including the right to an independent review of appeals

The Provider Resolution and CI teams are responsible for ensuring all required correspondence is sent and deadlines are met. Team leaders use compliance dashboards that are based on Contract requirements, audit tools, manuals, and other quantitative requirements. The dashboards include metrics focused on compliance measures and noncompliance indicators and are intended to be a point-in-time snapshot that provides team leaders insight into our overall compliance.

Our Provider 360 Committee provides oversight of the Medicaid provider grievances and appeals system and performance metrics. The Provider 360 Committee meets monthly to discuss and analyze performance data, analyze trends, perform root cause analysis, and identify potential process improvements.

g.ii. Process for tracking reasons for grievances and appeals to identify trends, and how the Vendor will use this information to improve internal operations, provider relations, and provider satisfaction.

PROCESS FOR TRACKING REASONS FOR GRIEVANCES AND APPEALS TO IDENTIFY TRENDS

To ensure we respond thoroughly to each grievance and appeal, Humana's highly trained Provider Resolution team uses an end-to-end tracking system built to process grievances and appeals consistently, within the Commonwealth-mandated timeframes, and in compliance with Kentucky statutes and regulations. Our proprietary CRM and inventory management tools are configured to comply with programmatic performance requirements, allowing us to track relevant deadlines, flag cases at risk, and adhere to programmatic obligations while compiling a full and complete record. This enables our associates to respond to providers with the information necessary to understand our rationale and mitigate future grievances and appeals.

Monitoring and Oversight: Monitoring and oversight are central to our provider grievances and appeals system. Our provider grievances and appeals monitoring process includes (1) comprehensive, real-time feedback to subsequent processes when appropriate and (2) root cause analysis for issues that span multiple providers. Comprehensive reporting on provider grievances and appeals trends can be generated by our system including:

- A reporting dashboard that provides up-to-the-minute, real-time inventory, progression, and aging of grievances and appeals and delivers the capability to see directly into case detail; the dashboard also provides ad hoc query capability
- A daily report on the status of all current provider grievances and appeals, applicable deadlines, and summary of any issues requiring further escalation
- A weekly dashboard that lists the number of provider grievances and appeals not resolved during the previous month, categorized by week and by the length of time the case has been open
- A monthly provider dashboard that rolls-up data from other reports displaying provider grievances and appeals data over the prior 12 months, showing trends in provider disputes as well as details about appeals decided by committees and external third-party reviews in accordance with Section 27.10(B) of the Draft Medicaid Contract

Trend Analysis: The monthly trended data include Humana's performance on timeliness metrics and the number and percent of provider grievances and appeals falling into each of the following categories:

- Type of grievance or appeal (claims-related, non-claims-related)
- Reason for grievance or appeal; type of provider (i.e., hospital, personal care provider)
- Location of provider
- Timeliness metrics and benchmarks for acknowledgements and notices, status updates to the provider and DMS, extension requests if applicable, resolution, and payment of claims following a resolution
- Resolution in favor of provider

The Provider Resolution team also uses **Clarabridge**, which is a robust data analytics tool, to conduct root cause analysis. The Clarabridge analytics engine allows us to achieve scalability and better insights from our data and derive insights more quickly. This automated tool allows for near real-time analysis of grievance and appeal drivers. For example, Clarabridge flagged a provider group that nearly overnight had an almost 1000% increase in claims appeals. The Provider Resolution team quickly ascertained that the provider group had hired a new billing manager. Our Provider Relations Team reached out to the new manager, quickly training her and resolving the issue.

In 2018, we began a pilot with Clarabridge to understand and provide feedback to upstream business partners on what is driving grievances and appeals inventory to mitigate provider friction points. In addition to topical categorization and text-analytic capabilities, Clarabridge allows us to understand sentiment, confusion, and effort involved with the provider's complaint/inquiry, grievance, or appeal. This enables us to be much more efficient in identifying a true grievance versus an inquiry or request.

To facilitate additional trend identification, we monitor the top five grievance types and the top five providers who have most frequently submitted a grievance. On a monthly basis, our Provider Relations representatives reach out to the top five in each of these categories. The Provider Relations representatives have one-on-one conversations with these providers about the specific issues, providing education and training as needed.

In addition, our Claims Research and Resolution team sends a report the first of each month to the Provider Contracting team manager. The report includes:

- Top five providers by volume of claim denials from the prior month
- Denial reason summary and details for each of the providers listed
- Demographic information necessary to identify, contact, and facilitate conversation with each provider

This report allows our Provider Resolution team to identify specific claims-related challenges for providers, and arrange general or targeted training to address the reasons for the denials. Examples of types of training and education we have completed with specific providers include:

- Claims and billing issues
- Continuity of care alert
- Target care management
- Medical foster care
- Custodial care

IMPROVING INTERNAL OPERATIONS

Identifying Opportunities for Improvement: Our cross-functional Provider 360 Committee provides a 360-degree view of the provider experience with Humana. The Committee's goal is to continuously improve our relationships with our providers. Chaired by our Provider Services Leader, Mary Sanders, the Committee includes market leadership and a combination of market and corporate support areas, including our Kentucky CCO, Kimberly Myers, Provider Relations, Claims Performance Management, Integrated Provider Solutions, and Provider Communications teams. The Provider 360 Committee meets monthly to discuss and analyze trend data, perform root cause analysis, and identify potential process improvements. A brief description of the participating teams and functions of the Provider 360 Committee is described below.

- Our Claims team identifies areas where our claims processing needs improvement and opportunities for additional provider education on claims submission
- The Regulatory Compliance team continuously monitors our performance as it relates to our DMS Contract requirements as well as our contractual arrangements with our providers
- The Provider Relations Team offers a provider perspective to grievances and appeals as well as identifying areas that need further provider education on our policies. This team recommends improvements to our provider support operations to better support our providers in serving our Enrollees.
- The Web/Digital team supports our provider portal where claims are tested and status provided
- Provider Escalation associates coordinate efforts between various provider-facing teams and provide support for process improvements
- Provider Communications is the central team that reviews and manages all provider communications through various outlets, such as our provider portal and newsletters

When trends and patterns are observed, the Provider 360 Committee assesses whether process improvements or system enhancements are needed. If so, the Committee refers the issue to the Medicaid Governance team for rapid-cycle prioritization and assignment to a project team to research the issue and report back on findings and recommendations. The Provider 360 Committee may also escalate opportunities for improvement to the LMOC, which is comprised of local senior leaders for analysis, resolution, and resource allocation when appropriate.

Monitoring Provider Satisfaction: We actively monitor provider satisfaction measures, such as feedback to our Provider Relations team, input from our PAC, voice of the customer surveys following interactions with our Provider Services Call Center, Provider Payment Integrity unit associates, and active measurement of our Net Promoter Score. Combined with provider grievances and appeals, these measures inform our process improvement decisions.

Feedback Loop: Humana also instituted a formalized Enterprise Feedback Loop that provides a holistic approach to analyzing and improving the customer experience. This Feedback Loop takes information from all sources of Enrollee feedback to Humana (including calls, emails, chat, social media, click stream, and other digital metrics), aggregates it, and uses machine learning to provide multi-level analytics to our business units. The system provides automated alerts to allow team leaders to keep a pulse on high-priority and frequently occurring issues so that we can be ready and timely responding to Enrollee needs. Our analytics allow us to gather actionable insights then address them to improve the customer experience. This tool also provides for continuous monitoring before, during, and after addressing feedback, so we can iterate on and continuously improve our methods to best meet our Enrollees' needs. **As our Enterprise Feedback Loop data develop and become more robust over time, they will include predictive capabilities to anticipate providers' needs**. Our Feedback Loop will use categorization models to define issues from our aggregated sources, allowing us to predict what kind of events or incidents may trigger negative feedback so that our leadership can modify operations before the event occurs.

g.iii.	Process for ensuring transparency to DMS of grievance and appeal types, resolutions, and any Vendor actions to decrease such grievances or appeals in the future.

PROCESS FOR ENSURING TRANSPARENCY OF GRIEVANCE AND APPEAL TYPES

Our approach to ensuring transparency with DMS of our grievance and appeal types and resolutions is to use our well-defined monitoring and oversight processes to provide accurate, thorough, and complete information to DMS. Humana's internal reports, metrics, and dashboards contain substantial, detailed information regarding grievances and appeals, their causes, resolutions, and trends. Our Medicaid oversight and monitoring system ensures our data are accurate, complete, and transparent. Specifically, our Operational Risk Management (ORM) unit works collaboratively with the Provider Resolution team to ensure compliance with CMS, Kentucky metrics,

and reporting requirements. ORM has processes that measure and monitor compliance performance specific to Contract requirements including:

- Compliance Scorecards: These monthly scorecards provide a point-in-time assessment of overall compliance for Medicare and Medicaid. The overall compliance ratings take into consideration key compliance indicators, including grievances and appeals timeframes, and specific criteria for risk ranking.
- Compliance Dashboards Metrics: These monthly dashboards are based on Contract requirements, audit tools, manuals, and other quantitative requirements. The dashboards include metrics focused on compliance measures and indicators of noncompliance, such as grievances and appeals, and are intended to be a point-in-time snapshot that provides Humana insight into our overall compliance.

Currently, we provide DMS with information about our provider grievances and appeals types and resolutions but believe that there is an opportunity for DMS to collect additional and more robust data. We recommend that, to improve transparency, DMS revise its provider grievance and appeal reporting requirements to:

- Clearly define "complaint," "grievance," and "appeal" and require all MCOs to use the same definitions
- Require each MCO to report their performance and compliance data using these definitions in the same manner and in the same template
- Add an analysis section to the report that requires MCOs to summarize trends and identify areas for improvement

Consistent, comparable data across plans will result in increased transparency and allow DMS to more easily identify areas for improvement for each plan and generally across the Kentucky MMC program.

PROCESS FOR ENSURING TRANSPARENCY OF RESOLUTIONS

Key to ensuring transparency of resolutions is to collect and track accurate data in a way that can be measured and trended so that DMS can view a complete picture of plan performance. Internally, Humana measures provider grievances and appeals through multiple dashboards that are used to produce the required provider grievances and appeals reports. Our Provider Resolution team associates code each grievance and appeal with a reason, and we track the top reasons for grievances and appeals across multiple measures such as provider type. We also require that all Subcontractors that are part of our provider network cooperate with our policies and procedures, including grievances and appeals reporting. The Subcontractors are subject to CAPs and financial penalties for non-compliance.

We believe there is an opportunity for Humana to work collaboratively to improve DMS's current provider grievances and appeals report (#41) to clarify the definitions used in the report. For example, the report refers to "informal grievances" and "grievances," but "informal grievances" are not defined by the Contract and are often used interchangeably with "complaints," which is also not defined clearly. Humana has experience receiving, resolving and reporting provider grievances and appeals in other Medicaid programs and across other service lines and would be willing to assist DMS in revising the report to ensure consistency, transparency, and clarity.

ACTIONS TO DECREASE GRIEVANCES AND APPEALS IN THE FUTURE

Our in depth oversight and monitoring processes (described in sub-question I.C.17.g.ii of this response) yields detailed insight into where we can improve our grievances and appeals operations and improve provider satisfaction. This monitoring occurs across multiple teams (Provider Relations, Provider Resolution, Enrollee Grievances and Appeals, etc.) on a daily, weekly, monthly, quarterly, and annual basis so that we are able to quickly address issues as they arise but also to view grievances and appeals over longer periods of time to note trends. Our clear system of accountability and tracking leads to continuous process improvements designed to reduce provider grievances and appeals overall.

To reduce grievances and appeals being submitted to DMS in the future, we will:

- Educate providers about our provider grievances and appeals process: We do this through numerous channels including during our mandatory orientation, through Availity, and through our Provider Manual. As part of our education efforts, we explain to providers that accessing our internal grievances and appeals system prior to going to DMS could lead to quicker and easier resolution.
- Continue to improve and adjust our data analytics systems to proactively prevent provider grievances and appeals: Our state-of-the art data analytics allows us to get a nearly real-time window into our provider grievances and appeals. Because of this, we can quickly identify if multiple providers are having a similar issue or if a single provider is having multiple issues. Under both circumstances, our Provider Resolution team coordinates with the Provider Services staff to ensure that providers' single point of contact, their assigned Provider Relations representative, contacts them to remedy the situation. For example, we recently had a provider who participated across all of our lines of business (Medicare, Medicaid, and Commercial) and experienced a significant increase in claims denials. Our analytics software identified the issue, and our Provider Relations representative contacted the provider where they learned the provider had adjusted their systems to incorporate changes in Medicare requirements that inadvertently affected their Medicaid operations, resulting in a high denial rate. Upon identification of the issue, we alerted our other providers of this potential risk. This proactive outreach and education effort likely prevented numerous claim denials and improved our providers' satisfaction, resulting in fewer grievances and appeals to DMS.