

C. Technical Approach

18. Provider Network (*Section 28 Provider Network*)

- a. Provide the Vendor's proposed Provider Network development strategy to ensure a comprehensive statewide network across all provider types. The Vendor's strategy must describe the following:

Through more than 50 years of experience serving communities in Kentucky, Humana has refined our provider network development strategy to create an accessible network of high-quality providers who help Enrollees achieve health and well-being across all of our lines of business. Our local Kentucky Provider Network team, led by our Provider Network Director, Majid Ghavami, **has more than 107 years of combined contracting experience** and continually works to expand our existing provider network and maintain collaborative provider relationships. We continuously assess, evaluate, and evolve our provider network development strategy to ensure we have a comprehensive, statewide network across all provider types while proactively addressing provider needs. Key elements of our network development strategy, described in detail in the following pages, include:

Kentucky is Humana's home. For more than 50 years, we have served Kentuckians' healthcare needs. We are deeply rooted and invested in Kentucky, with more than 12,000 associates and 25 offices in the Commonwealth. Our locally based associates facilitate the delivery of high quality care to more than 145,000 Medicaid Enrollees.

- **Deploying innovative recruiting tactics**, which include offering value-based payment (VBP) models to recognize providers and help them achieve our shared quality goals; reducing provider burden through administrative simplification; partnering with provider entities and implementing telehealth solutions to increase access in underserved and workforce-shortage areas; and leveraging provider relationships in border states to address network access challenges
- **Facilitating out-of-network (OON) care when necessary** through immediate interventions to ensure short-term care needs are met, as well as through longer-term interventions to resolve access-to-care challenges
- **Ensuring appropriate accessibility and accommodations** for Enrollees by conducting provider site reviews and proactively assisting Enrollees to overcome access-to-care barriers
- **Providing care that is culturally competent and linguistically appropriate** through training and education opportunities, in partnership with community organizations, for Humana associates and contracted providers
- **Leveraging our existing Kentucky footprint and relationships to manage unforeseen circumstances**, such as higher enrollment rates, to ensure sufficient network capacity and continuity of care for Enrollees

These strategies have enabled us to build a high quality and accessible provider network. Our network submission files (please see our response to sub-question I.C.18.e of this Request for Proposal as well as **Attachment I.C.18.e-1 and Attachment I.C.18.e-2**) illustrate the full breadth of our Kentucky network and include the following highlights:

- 3,525 adult Primary Care Providers (PCP)
- 891 pediatric PCPs
- 3,192 behavioral health (BH) providers
- 731 OB/GYNs
- 978 adult and pediatric dentists

Humana has Medicaid contracts with all FQHCs, CMHCs, and acute care hospitals in Kentucky.

Our Enrollees also have convenient access to more than 1,040 pharmacy locations.

We have existing contracts with all Federally Qualified Health Centers (FQHC), Community Mental Health Centers (CMHC), and acute care hospitals in the Commonwealth, maximizing access to care for our Enrollees. We continuously monitor and evaluate the adequacy and availability of the network, which informs our ongoing provider network development strategy.

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Innovative approaches to recruit providers and to develop and maintain the Vendor's provider network to ensure network adequacy standards and highest quality care, including:

Our success in establishing a robust network that is responsive to Enrollees' needs starts with building collaborative relationships and offering meaningful supports and incentives to providers. Our provider recruitment activities are an extension of these longstanding relationships and have been tailored to meet the unique needs of 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 FQHCs in Kentucky participate in Humana's Medicaid provider network.** Our comprehensive, high-touch provider services model is designed to allow us to truly partner with providers meeting the unique needs of Commonwealth residents and supporting providers in the evolution and transformation of their practices. This intentional high-touch model supports provider recruitment and retention. We highlight the core strategies of our provider recruitment and retention model below and elaborate on our expansive, high-touch functions on the ensuing pages of this response:

Humana is the Medicaid MCO of choice for The Lexington Clinic. With more than 200 providers in more than 30 specialties, the Lexington Clinic is the largest multi-specialty clinic in Central Kentucky.

- [REDACTED]
- Provide administrative simplicity with deep local supports
- Offer "high-performing provider status" to top providers
- Promote provider retention and satisfaction through provider outreach, engagement, and timely claims payment
- Monitor and expand network capacity through strong local connections with providers across Medicare and Commercial lines of business, any willing provider contracting, and leveraging of telehealth resources

VBP PROGRAMS

Our VBP programs help with provider recruitment and retention because they offer an opportunity for providers to achieve reimbursement well above baseline Medicaid rates. [REDACTED] to Kentucky providers. VBP can also reduce administration burden for providers in risk arrangements where prior authorization (PA) requirements are waived.

Our VBP programs for Kentucky Medicaid include incentives for primary care providers (PCPs), BH providers, and OB/GYNs. We will reward network providers through a continuum of VBP arrangements that incentivize providers to undertake initiatives to reduce preventable events, improve chronic condition care delivery, reduce medical costs, and improve Enrollee satisfaction. [REDACTED]

[REDACTED] The positive health outcomes and meaningful incentives help us forge and maintain strong partnerships with providers who serve our Enrollees.

For our OB/GYNs, offering VBP programs is essential to our recruitment and retention strategy. Our VBP strategy for OB/GYNs focuses, in part, on pertinent issues such as prenatal and postpartum care. For BH providers, we

offer several VBP programs, [REDACTED].

Our VBP strategy also includes a Practice Transformation Incentive, which qualifying practices can use to make strategic investments to overcome barriers to VBP success and promote practice transformation. If our provider partners are granted this incentive, our **Practice Innovation Advisor** collaborates with the providers to maximize the PTI's potential reach. For example, providers can use this incentive for initiatives such as adding a BH staff member and building out health information technology or telehealth capabilities.

ADMINISTRATIVE SIMPLICITY

In 2016, Humana began a journey to improve the provider experience by creating a strategy to optimize provider support and align resources, reduce touch points, and simplify the provider experience. This was achieved by defining accountability and strengthening collaboration between the different areas at Humana both at the corporate and market levels. One resulting initiative is Humana's **Gold Card** program, which aims to reduce providers' administrative obligations related to PA. Gold Carding uses a blend of quality and performance measures to identify high-performing providers who excel at closing care gaps and referring Enrollees for appropriate services and follow up. Gold Card status allows providers to bypass the standard outpatient PA process for the following services: referrals for specialty care, in-office or ambulatory surgery procedures prevalent among specialty providers, small molecule prescription products, high-cost biologics, and high-tech imaging (e.g., CT/MRI). This program helps us achieve mutual quality and access goals while reducing administrative burden on providers. Our Florida Statewide MMC program is rolling out a Gold Carding pilot early this year and we commit to implementing a pilot in the Kentucky MMC program in early 2021.

We have also invested significant resources in our provider portal, Availity, to give providers the mechanisms they need to support their practices including up-to-date financial information, Enrollee data, and access to tools (such as our Claims Code Editor) so providers may test and amend claims prior to submission. The implementation of strategies to decrease the number of post-payment recoveries and the institution of a "live line" for providers to access Humana associates with specialized expertise in addressing claims issues has decreased providers' frustration with recoupments and claim concerns.

HIGH-PERFORMING PROVIDER STATUS

We utilize our Care Decision Insights platform to provide in-depth reviews of performance measures for efficiency and effectiveness of specialist groups based on claims data. These data can assist PCPs 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. Additionally, our automated PCP assignment process prioritizes high-performing providers to ensure Enrollees receive the highest quality of care.



PROVIDER ENGAGEMENT AND SATISFACTION

Provider satisfaction and network retention are of the utmost importance to Humana. We work diligently to monitor provider satisfaction, seek input from network providers to inform our operational improvement initiatives, and ensure timely claims payment. We actively monitor provider satisfaction and gather feedback to improve providers' experience doing business with Humana. Monitoring tools include:

- Feedback from our Provider Relations representatives in the field
- Input from our Provider Advisory Committee, which is comprised of network providers
- Provider grievances
- Voice of the Customer surveys

- Annual provider satisfaction surveys

Humana also uses the following forums to communicate with and seek input from providers:

- Regional Provider Seminars: We will routinely conduct provider seminars in each Medicaid 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 recruit and engage providers. Our regular attendance has helped bolster our relationships and recruitment efforts with participating members of these associations.
- 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 current and Draft 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: We will conduct town halls in the Commonwealth by hosting events in each Service Region regularly

Finally, we recognize that timely, accurate claims payment is critical to providers' ability to serve our Enrollees. We have designed Humana's claims strategy with the ultimate goal to **"pay it right the first time."** Our strategy has four dimensions: 1) supporting providers with self-service tools that help them file claims correctly the first time, 2) education and training to ensure they have the latest information on claims filing, 3) identifying providers who consistently have high rates of claims denials, and 4) providing targeted assistance to those providers with high claims denials.

MONITOR AND EXPAND NETWORK CAPACITY

Our Provider Network team continuously monitors and evaluates the geographic accessibility of our network. In the event we identify a geographic gap for a provider type, we initiate enhanced and focused recruitment activities. One method identifies providers in our Medicare and Commercial networks who are not participating in our Medicaid network. Through our provider support and engagement activities, which include scheduled provider visits and frequent telephonic and interactive touchpoints, our Provider Services staff discuss expanding the provider's relationship with Humana to include Medicaid network participation. Another method capitalizes on referrals from existing in-network Medicaid providers to specialists whom they routinely refer Medicaid Enrollees for follow-up services. If the specialist is not already participating in our network, our Provider Services staff perform outreach and offer a contract for participation. Humana also has a number of national partnerships with telehealth providers (e.g., Arcadian Telepsychiatry), which can help bolster access particularly in rural and underserved areas. Humana's provider network activities comply with the Commonwealth's any willing provider statute as described in 907 KAR 1:672 and as amended by KRS 304.17A-270. We continue to look for opportunities to expand our network to include all willing providers in the Commonwealth, as well as those located in bordering states. To ensure the highest quality of care is available to our Enrollees, we require all providers to comply with the terms and conditions of participation as outlined in our provider contracts, credentialing standards, and supporting materials, including State Medicaid requirements for participation.

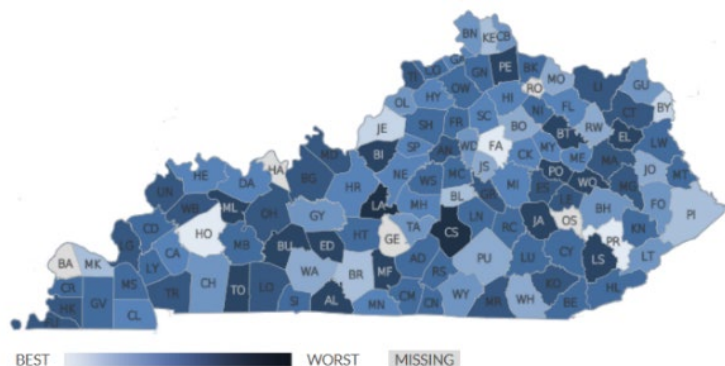
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Strategies to recruit providers in traditionally underserved as well as non-urban areas, by health need, and to overcome expected accessibility challenges.

Humana knows Kentucky – we recognize there are many areas where access to care is a longstanding challenge. Based on data from the 2019 County Health Rankings, 97 of the 120 counties in the Commonwealth have a population-to-PCP ratio exceeding the Department’s required maximum of 1,500:1. Examples in Casey County, where the population-to-PCP ratio equates to more than 15,000:1, and in LaRue County, where there are more than 14,000 residents for every local PCP, highlight challenges that Kentuckians face when trying to access care. The story is the same for mental health and dental providers. The 2019 County Health Rankings show that Kentuckians in Crittenden, Rockcastle and Ballard Counties have, on average, more than 8,000 residents per available mental health provider. In McCreary County, access to dental services is extremely insufficient with more than 17,000 residents for every local dentist.

Exhibit I.C.18-1: Ratio of population-to-PCPs

The 2019 County Health Rankings used data from 2016 for this measure.



Humana employs several strategies to reduce access challenges across all provider types in all regions of the Commonwealth.

Full Market Analysis: To inform our recruitment efforts in underserved areas and throughout the Commonwealth, we consider population health priorities identified by the Department, including asthma, heart disease, diabetes, obesity, tobacco use, cancer, infant mortality, low birth weight, BH, and substance use disorder (SUD). In addition to the priority conditions listed in Section 34.2 Conditions and Populations of the Draft Medicaid Contract, Humana also considers the following to be priority conditions among our Kentucky Medicaid membership:

- HIV/AIDS
- Hepatitis C
- Sickle cell disease (SCD)

Particular Service Regions of the Commonwealth are more intensely affected by these specific health concerns than other areas; however, our Provider Network is designed to provide access to Enrollees across all health needs and provider types statewide.

Improving Access to Care Strategies: Humana’s Provider Network team continually seeks opportunities to improve access to care in underserved areas. We are working to develop partnerships targeted at increasing access to PCPs, OB/GYNs, BH providers (including SUD services), and dental services. These provider types are most closely aligned in caring for Enrollees with the health needs described above. A particular priority is identifying partnerships to integrate social and community-based services with clinical care. In May 2019, the **Humana Neighborhood Location in Covington, which is operated in partnership with St. Elizabeth physicians, opened. Our Neighborhood Location increases access to clinical care as well as community services for Enrollees.**

Primary Care Providers (PCP): Humana’s network includes all FQHC providers in the Commonwealth. We are exploring ways to deepen our partnerships to expand access to primary care services through the development of an in-home visiting doctor program and telehealth capabilities.

Telehealth and remote monitoring support providers, particularly those in rural counties, in improving collaboration with Enrollees who have difficulty accessing care. Our telehealth strategy is multi-pronged, including reimbursement, partnerships with providers, and direct-to-Enrollee digital health platforms. Three key partnerships to support providers include:

- **Telepsychiatry:** We are partnering with Arcadian Telepsychiatry to provide scheduled virtual video and telephonic psychiatry, psychology and therapy visits. Services include diagnostic assessment, ongoing counseling, ongoing medication management, and care management. Our partnership increases access and availability to BH services through a robust network of psychiatrists, psychologists, licensed professional counselors, licensed marriage/family therapists, and licensed clinical social workers.
- **MDLIVE:** We will use MDLIVE's virtual care platform to offer our Kentucky Medicaid Enrollees telehealth capabilities aimed at reducing emergency department (ED) visits. Enrollees will have access to a) **urgent care** through which they can access licensed healthcare professionals for diagnosis and treatment of common ambulatory illnesses, and b) **BH and well-being services** through telebehavioral health and telepsychiatry, where Enrollees can see a licensed therapist face-to-face from the comfort of their home.
- **Diabetes mobile health application:** We have partnered with WellDoc to access its diabetes mobile application, BlueStar, to address clinically proven dimensions of diabetes management. BlueStar connects Enrollees and their care teams through two-way chat functionality and supports clinicians through clinical decision support tools and a population management dashboard.

OB/GYN Providers: Humana's network includes 731 unique OB/GYN providers, inclusive of maternal and fetal medicine specialists. Our Provider Relations representatives, led by Kentucky Medicaid Provider Services Manager, Michelle Weikel, RN, CCM, regularly visit and communicate with OB/GYN offices to educate providers on our maternity care management program, MomsFirst. For high-volume OB/GYN offices, a Humana Care Manager (CM) attends provider education visits with the Provider Relations representative to provide additional context and information on care management services. We also offer OB/GYN providers an additional reimbursement incentive for completion and return of the Notification of Pregnancy form. This notification helps us to identify high-risk Enrollees early on in a pregnancy. Our MomsFirst, Neonatal Intensive Care Unit (NICU), and incentive programs provide additional support to our network OB/GYN providers in the monitoring and care of our pregnant Enrollees.

Mental Health Providers: **Humana is partnering with Springstone, Inc. to increase access to BH in traditionally underserved areas.** The partnership includes opening new outpatient facilities throughout the Commonwealth to provide Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP). Springstone is a national provider of high-quality BH solutions with a reputation for bringing new services to populations in need of mental health and chemical dependency support. Enrollee access to these facilities will help to de-escalate serious mental illness (SMI) symptoms before the Enrollee decompensates to the inpatient level of care. Springstone provides step-down services for Enrollees including children and adolescents who have been discharged from inpatient facilities and for Enrollees who need more intensive care than can be provided in a regular office setting. Services include group therapy programs and classroom sessions for school-aged children. Springstone additionally offers transportation programs to assist Enrollees in accessing care, thereby, decreasing their dropout rate and reducing the burden on families.

SUD has taken a considerable toll on the health of Kentuckians. The Commonwealth ranks third in the United States in overdose deaths, and families residing in Kentucky's rural communities are disproportionately impacted by the opioid crisis. Humana recognizes the high need for accessibility to SUD providers, and we have targeted recruitment and established contractual relationships with local, regional, and nationally recognized providers, including Behavioral Health Group, Spero Health, and SUN Behavioral Health, to offer a full spectrum of comprehensive, clinically sound services, including SUD programs to our Enrollees

We have partnered with several Kentucky BH providers, including Behavioral Health Group, Pinnacle and Spero Health, to **develop bundled payment VBP programs** for MAT.

statewide. Exemplifying our strategy to overcome accessibility challenges to SUD providers, Humana is deepening our relationships with SUN Behavioral Health and St. Elizabeth Healthcare, both located in northern Kentucky, a region that has been acutely impacted by the opioid crisis. Our Enrollees have access to SUN Behavioral Health's expansive detox and inpatient and intensive outpatient services, including medication-assisted treatment (MAT), for those suffering from addiction. Humana and SUN Behavioral Health are in the process of expanding our current relationship to include engagement in VBP.

Another serious health need in Kentucky and across the nation is the assessment and approach to addressing **adverse childhood experiences (ACEs)** that widen disparities in care and increase health-related risk behaviors such as smoking, substance abuse, eating disorders, and teenage pregnancy, among other negative behaviors. Providers trained in trauma-informed care (TIC) are more equipped with the tools to identify, assess, and treat patients exhibiting the subsequent effects of ACEs. Humana has partnered with Relias to offer 20 TIC training modules to our network providers. The training discusses aspects of trauma-informed clinical best practices, screening and assessment, treatment objectives, and trauma-specific treatments and recovery. Continuing Education Credit is available to providers who complete the training.

Offering our Enrollees a provider network that supports **integrated physical and behavioral health** is a key component of Humana's strategy to overcome accessibility challenges in rural and underserved areas. To encourage further adoption of integrated health access, Humana offers providers payment support through our VBP programs. PCPs have access to the **Practice Transformation Incentive**, which they may use to add staff to service the BH needs of Enrollees. Our VBP program also includes a referral bonus for BH providers who successfully encourage their patients to see their PCP. For provider practices that are Patient-Centered Medical Home (PCMH) recognized or are in the process of becoming certified, our VBP model offers an additional per member per month (PMPM) payment and opportunity for shared savings. The breadth of our VBP program offers substantial incentives for PCMHs to make other infrastructure changes that enhance the model of care such as embedding care coordinators in their practice and using electronic health records (EHR).



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Strategies and methods to address workforce shortages and network gaps, included proposed initiatives to collaborate with the Department and other contracted MCOs to develop innovative solutions to meet the healthcare needs of Enrollees.

According to the Health Resources and Services Administration (HRSA), there are currently 53 primary care, 14 dental, and 23 mental health geographic Health Professional Shortage Areas (HPSA) in Kentucky, of which 19 primary care, five dental, and 13 mental health HPSAs have scores of 14 or higher. Shortage areas are scored from zero to 26 where the higher the score, the greater the need. Humana is committed to addressing these shortages in our home state and improving access to care for our Enrollees and the Commonwealth as a whole. Below, we outline our strategies and methods to address workforce shortages and network gaps. Strategies to address workforce shortages and network gaps include collaboration, Peer Support Specialists, telehealth, dental mobile health services, and digital health solutions.

STRATEGIES TO ADDRESS WORKFORCE SHORTAGES

Peer Support Specialists: To develop community support services for SUD further, Humana is committed to funding certification for 50 Peer Support Specialists to increase access to mental health services for our Enrollees. We will work with local advocacy groups, including the local National Alliance on Mental Illness (NAMI) chapters, Mental Health America, and family advisory councils to connect Peer and Family Support Specialists with individuals in need. These specialists have first-hand experience with addiction and have personal recovery stories, combined with the insight and maturity to be a guide and mentor. Our Peer Support Specialists will receive formal training in motivational interviewing, Wellness Recovery Action Plan®, living with

certain chronic medical conditions, and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Eight Dimensions of Wellness prior to engaging with our Kentucky Medicaid Enrollees.

Telehealth: Humana fully embraces the use of telehealth to increase access and provider capacity. Our telehealth solutions for our Kentucky Medicaid Enrollees include:

- MDLIVE: We will use MDLIVE's virtual care platform to offer our Kentucky Medicaid Enrollees telehealth capabilities aimed at reducing ED visits. Enrollees will have access to (a) **urgent care** through which they can access licensed healthcare professionals for diagnosis and treatment of common ambulatory illnesses, and (b) **BH and well-being services** through telebehavioral health and telepsychiatry, where Enrollees can see a licensed therapist face-to-face from the comfort of their home, and (c) **primary care virtual visits** to address follow-up care needs between visits with Enrollees' PCP and to access primary care for healthcare needs.
- Telepsychiatry: We are partnering with Arcadian Telepsychiatry to provide scheduled virtual video and telephonic psychiatry, psychology and therapy visits. Services include diagnostic assessment, ongoing counseling, ongoing medication management, and care management. Our partnership increases access and availability to BH services through a robust network of psychiatrists, psychologists, licensed professional counselors, licensed marriage/family therapists, and licensed clinical social workers.

Telehealth in Public Schools: School-based telehealth programs can be an impactful way to improve health outcomes for children. With new telehealth technology, special computer-connected otoscopes and stethoscopes allow doctors to check ears, noses, throats, and heartbeats from remote locations. Students referred to the nurse can receive a virtual doctor's visit to diagnose common illnesses such as inner ear infections, allergies, pinkeye, and upper respiratory infections, among other conditions. These innovative programs improve access to care and perhaps more importantly, they offer convenient access to care. Without school-based telehealth programs, children often need their parents to take time off work for doctor visits. For low-income families, skipping a shift at work to visit a provider can have serious consequences, but delaying treatment leads to preventable ED visits and hospitalizations.

In an effort to improve access to care for Kentucky children, Humana is supporting the advancement of Norton Healthcare's school-based telehealth program in Jefferson County Public Schools. Humana will sponsor the telehealth technology that Norton Healthcare uses to remotely examine the student with the assistance of the school nurse.

Our support of Norton Healthcare's expansion of telehealth technology in public schools located in underserved areas will **reduce disparities in access to care** while improving the overall health of the community. Humana and Norton Healthcare see this as an opportunity to keep children in school, healthy, and learning.

Digital Health Solutions: Humana will offer digital health solutions including mobile applications that address workforce shortages in rural areas through remote monitoring technology and the use of physician extenders. The following describes how our mobile applications will address patient needs:

- Diabetes Management: Humana is teaming with **WellDoc** to introduce an innovative digital therapeutic application proven to be successful at controlling the blood sugar levels of persons with diabetes and reducing associated costs through real-time feedback on critical aspects of Enrollee lifestyle and behavior. The WellDoc diabetes app, known as **BlueStar**, is designed to address clinically proven dimensions of diabetes management: exercise and sleep habits, diet, psychosocial factors, clinical symptoms, medication adherence, and lab results such as blood glucose levels. BlueStar incorporates feedback from Enrollees to promote self-management of critical behaviors, such as diet and exercise, and to communicate lab results and other aspects of care management to Enrollees and their clinical team. BlueStar connects Enrollees and their care teams through two-way chat functionality and supports clinicians through clinical decision support tools and a population management dashboard.

- **Pregnancy:** Our partnership with **Pacify** gives pregnant women access to physician extenders 24 hours a day, seven days a week (IBCLCs, RNs, and others) using a proprietary, video-enabled call-routing system that activates statewide provider networks. The technology connects a pregnant Enrollee to a live resource within 30 seconds or less, providing access to services at acute moments when the ED is often the only available alternative. This mobile application also provides Enrollees with information about their pregnancy benefits, as well as timely nudge notifications regarding prenatal visits, vaccines, postpartum visits, and other milestones.

Dental Mobile Health Services: Humana has partnered with Avēsis to provide dental services to our Enrollees through Avēsis' comprehensive statewide network. In addition to office-based providers, Avēsis brings dental care to Enrollees who reside in designated dental provider shortage areas via portable mobile units that currently provide services at 226 locations across the Commonwealth. These mobile units deliver services at a wide variety of locations including schools, long-term care facilities and SUD facilities, among others. Because of Avēsis' extensive, combined office-based and mobile service platforms, our Enrollees have access to a dental provider within 50 miles/50 minutes of their home. On average, our Enrollees have access and choice of at least three dental providers within 4.9 miles/5.4 minutes of their home.

To further extend dental care access to our Enrollees in underserved provider shortage areas, we will use Avēsis' tele-dentistry service. Tele-dentistry expands access to dental services for Enrollees who, for example, live in rural areas without a sufficient supply of dentists or with limited access to transportation. In partnership with the KPCA, Avēsis will pilot tele-dentistry in Kentucky through selected FQHC and Rural Health Clinic (RHC) partners. We plan to include collaboration with local health departments in the pilot to engage public health hygienists in delivering virtual care.

Additional activities to expand access to dental health services include holding community events in rural areas targeting dental education and care and the development of a pilot to offer dental services in public schools targeting children with care gaps.

PROPOSED COLLABORATION INITIATIVES

Upon Contract award, we will initiate a collaborative effort with the Department and all selected Managed Care Organizations (MCO) to expand the primary and BH workforces in designated workforce shortage areas. Actions of the collaboration may include, but are not limited to, supporting initiatives that create opportunities for medical schools and para-medicine programs to partner with high schools in shortage areas. These partnerships may include designing and offering courses for high school students interested in careers in medicine. Participating students meeting the program's qualifications will be eligible for advanced degree scholarships, contingent upon agreement to practice in a workforce shortage area upon graduation and receipt of required credentials for their specialty.

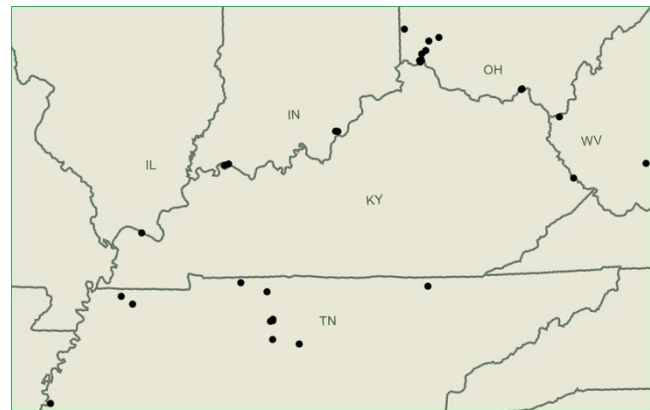
Additional collaborative opportunities may include developing and sponsoring certification programs for local emergency responders to deliver on-demand house call services for Enrollees with accessibility challenges. These programs can increase capacity and provider availability in workforce shortage areas. In partnership with area health systems and hospitals, an Emergency Medical Technician (EMT) or other medical professional can be dispatched directly to an Enrollee's home for assessment and treatment. Using a tablet device, the first responder will be able to contact a participating physician or nurse practitioner once they arrive at the Enrollee's residence for a telehealth consult, including point-of-care testing and medication prescribing. **Ultimately, this program reduces inappropriate use of the ED, increases access to care for Enrollees, and increases existing provider workforce capacity.**

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Strategies for contracting with providers in bordering states to help address network adequacy challenges, including lessons learned and successes or challenges with this approach.

Kentucky borders seven states from the Midwest and the Southeast. We recognize that for Enrollees living near the border, the majority of accessible providers may be located in a neighboring state. Therefore, access to high-quality care depends on cross-border contracting. Humana is able to leverage our strong Medicare and Commercial networks in neighboring states to provide access to care for our Enrollees living in the border vicinities, including access to nationally recognized, highly acclaimed pediatric specialty and sub-specialty providers. For example, Cincinnati Children's Hospital, which is ranked by U.S. News and World as one of the top three children's hospitals in the country for 2019-2020, is included in our Kentucky Medicaid network in order to provide access to these high quality services.

Exhibit I.C.18-2: Contracted hospitals in bordering states



We currently have existing contracts with providers in Illinois, Indiana, Missouri, Ohio, Tennessee, Virginia, and West Virginia. In 2019, our Enrollees had more than 118,000 visits with providers in bordering states. **In addition to access to more than 2,000 primary and specialty care provider locations, Humana's Enrollees also have access to 37 border state acute care hospitals in bordering states.**

Through our continuous provider recruitment efforts, we identify and contract with providers in bordering states who routinely see Kentucky Medicaid patients. If we are unable to identify a provider in our existing networks who can meet Enrollees' needs, our Provider Network team conducts outreach to OON providers and works to negotiate a letter of agreement to ensure we can meet the Enrollee's immediate needs. Subsequently, we work with that provider on a long-term participation agreement. We also proactively identify providers in neighboring states that offer exceptional, high-quality services so that we may make those services available to Enrollees.

Lessons Learned, Challenges and Successes

Our longstanding relationships with bordering state provider partners have helped alleviate network adequacy challenges. **Border state providers include, but are not limited to, including Cincinnati Children's Hospital, St. Jude Hospital, OrthoCincy, Deaconess Hospital, and St. Elizabeth's Hospital (Exhibit I.C.18-2).** Through our continuous network monitoring, we are able to identify the top providers and top specialties utilized by our Enrollees in each border state. For example, we know that our Enrollees living on the border with Ohio most commonly seek hospital services (i.e., outpatient, inpatient, emergency) from our participating Ohio-based providers, with Cincinnati Children's Hospital, Southern Ohio Medical Center, and University Hospitals being the top three providers of these services. Meanwhile our Enrollees living on the border with West Virginia most commonly seek radiology and OB/GYN services from our participating West Virginia-based providers. These data help us target our provider network recruitment strategies within Kentucky, as well as spurs the development of innovative partnerships, such as telehealth and healthcare workforce development, to improve access.

Managing provider relationships in bordering states comes with its unique set of challenges, including variation in Medicaid reimbursement, credentialing, and contractual requirements across states and provider confusion about the operating status of Medicaid MCOs from state to state. To help address these challenges, we provide, for example, the same assistance with provider enrollment and credentialing for our providers in bordering states that we offer Kentucky-based providers. Our Kentucky-based Provider Network team routinely collaborates with its counterparts in bordering states to develop and nurture the relationships with bordering state providers who serve not only our Kentucky Medicaid Enrollees, but also Enrollees across all of Humana's lines of business active in the Commonwealth. Humana's success in maintaining a comprehensive border state

network is due in large part to our high-touch provider services, engagement model, and administrative simplification efforts.

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Approach to providing out-of-network care when timely access to a Network Provider is not possible, including the Vendor's approach to supporting Enrollees in accessing such care.

While our network monitoring approach focuses on proactively identifying access issues, we have response mechanisms to rapidly facilitate provider access when necessary. When an Enrollee is unable to access a pharmacy, hospital, PCP, or other specialist within the required travel distances, Humana launches a two-pronged approach to remediate the network deficiency. The first approach is to implement an immediate process to ensure the Enrollee can obtain the necessary service. The second approach is to design and implement an aggressive and prompt recruitment plan. We will notify and work with the Department upon identification of major gaps or network deficiencies. The following immediate and longer-term strategies are ongoing, consistent practices built into our Network Management processes.



IMMEDIATE INTERVENTIONS TO ADDRESS ACCESS TO CARE ISSUES

Our Provider Network team uses several interventions, described below, to address access to care issues. If a qualified provider is unavailable within the travel distance of an Enrollee's residence, we may:

- Execute a single case agreement with an OON provider as an Enrollee-specific intervention
- Execute a letter of agreement with an OON provider to deliver Covered Services, allowing any Enrollee in a geographic area to access the provider. Additionally, we may use a letter of agreement as a bridge while we are negotiating contract terms with the non-participating provider
- Execute a contract with an OON provider and expedite the credentialing process to ensure our Enrollees receive Covered Services
- Arrange transportation for the Enrollee to the nearest qualified provider, per the pattern of care
- If we identify a deficiency in our pharmacy network, we will consider mail-order pharmacy, if appropriate; we also will search neighboring community pharmacies to determine if a home delivery option is available

LONGER-TERM INTERVENTIONS TO ADDRESS ACCESS TO CARE ISSUES

Our longer-term strategy is to develop a prompt and aggressive recruitment and remediation plan. We will:

- Encourage provider groups to recruit additional providers, including physician extenders
- Encourage providers to extend their appointment availability hours to accommodate more patients and increase access to care within time and distance standards
- Work with providers to re-open their closed panels to accept new patients
- Work with PCPs to identify specialty providers they frequently refer to for recruitment to include in our network
- Leverage existing Humana Medicare and Commercial network relationships in Kentucky by identifying providers in the area contracted for other Humana lines of business who could be added to our Medicaid network
- Use available resources to identify specific providers to target, such as Department provider listings by Service Region, the American Medical Association (AMA) website, U.S. News Health Report, and other plans' provider directories
- Use telehealth when appropriate and available

a.iii.

Approach to ensure Network Providers are physically accessible and have accommodations for Enrollees with physical or mental disabilities.

Humana has various processes, tools, and supports to ensure that Enrollees with physical or mental disabilities have appropriate accommodations and are able to access care. These include credentialing, Enrollee supports, and provider education.

ENSURING ACCESS FOR ENROLLEES WITH DISABILITIES

As part of our oversight process, we have procedures in place to review our network providers based on Centers for Medicare and Medicaid Services (CMS) and other federal and State regulations regarding accessibility for Enrollees with physical or mental disabilities. Every provider goes through a credentialing process and review to ensure the offices are physically accessible and provide effective communication services. In alignment with federal law, our providers are contractually required to be compliant with the Americans with Disabilities Act (ADA). These steps allow us to monitor for accessibility compliance on the front-end of a provider relationship and preemptively identify potential concerns.

Additionally, our Provider Services staff may identify potential noncompliance with ADA requirements during an office visit. If any noncompliance is identified, Humana takes appropriate action, which may include, but is not limited to, freezing the PCP's panel to new Enrollees and implementing a corrective action plan. Providers on a corrective action plan are re-audited after 30 days. Failure to resolve the noncompliance at the end of the corrective action plan period may result in termination.

SUPPORTS FOR ENROLLEES WITH DISABILITIES

Humana's Concierge Service for Accessibility works with our Enrollees who have physical or mental disabilities, are English Language Learners, or have another barrier to accessing care by providing auxiliary aids to ensure effective communication occurs. Our Concierge Service identifies challenges Enrollees may have in accessing services and works to resolve them before they become a barrier. Enrollees can access the Concierge Service for Accessibility in a variety of ways, including calling the Non-Discrimination phone line, calling our Member Services Call Center, and being referred by a Humana associate, including CMs, Community Health Workers (CHW), and Member Services Representatives (MSR), or a provider.

The Humana Concierge Service team also assists Enrollees directly in accessing our extensive language assistance, including American Sign Language (ASL) and languages other than ASL. For example, the Concierge Service team currently provides ASL interpretation services to a Humana Enrollee in Eastern Kentucky where ASL interpreters are difficult to arrange. To accommodate the Enrollee during provider visits, Humana arranges and compensates an ASL interpreter from Lexington, Kentucky, for the service as well as their travel time to the Enrollee.

For Enrollees in care management, their CM works closely with Concierge Service to ensure Enrollees have timely access to needed services while still preserving a single point of contact for our Enrollees. The following example exemplifies this close working relationship between our Kentucky Medicaid CMs and Concierge Service to assist our Enrollees efficiently and effectively. A Humana MomsFirst CM contacted the Concierge Service team to access translation services for our Enrollee, who spoke Kinyarwanda, to facilitate her enrollment in our MomsFirst Program. The CM was quickly connected to an interpreter who was fluent in Kinyarwanda and together they contacted the Enrollee. As a result of the interaction, they were able to complete our Enrollee's enrollment into the program and talk to the Enrollee to understand her background, goals, and needs in the first phone call.

After an Enrollee (or their provider, CM, caregiver or guardian) has contacted the Concierge Service team, the Enrollee is included on the Concierge Service's roster. An associate from the Concierge Service proactively contacts Enrollees periodically to inquire about their needs and assist them in arranging healthcare services and/or supports within Humana (e.g., care management).

Humana operates in accordance with Title VI of the Civil Rights Act; Sections 504, 508, and 1557 of the Affordable Care Act; Age Discrimination Act; ADA; and Executive Order 13166. In the instance that we learn a

provider in our network has become non-compliant with ADA laws and regulations, Humana's Concierge Service works with the affected Enrollee(s) to ensure they are able to access services with alternative providers either in or OON (if need be). Our Concierge Service also coordinates with our Provider Services staff and Kentucky Medicaid Network Director to ensure the provider is correcting deficiencies (as described in sub-question I.C.18-d).

Provider Education

Provider education is a key strategy used to ensure network providers are accessible and accommodate all Enrollees regardless of intellectual, developmental, or physical disability and is included as part of our required cultural competency training. Our trainings involve a combination of webinars, online modules, and face-to-face sessions in provider offices to ensure that information is current, accessible, and convenient. Our broad range of online training modules takes a deeper dive into understanding disabilities and includes, but is not limited to, topics outlined in **Table I.C.18-1**.



Table I.C.18-1 Disability Training Modules

Course Name	Brief Description
Disabilities Overview	Looks closer at what the term disability means and provides an overview of the different types of disability
Intellectual Disability Overview	Covers the definition of intellectual disability (ID), how a person with ID is diagnosed and evaluated, and some of the causes and signs of ID
Intellectual Disability Part 1: Understanding the Construct and Its Assessment	Discusses intellectual disability, its five assumptions, the constructs boundaries, a multidimensional model, supports, and assessment
Intellectual Disability Part 2: Assessing Intellectual Functioning and Adaptive Behavior	Defines and discusses accurately assessing intelligence and adaptive behavior, especially the measuring and interpreting of IQ scores
Intellectual Disability Part 3: Diagnosing Intellectual Disability and Planning for Supports	Addresses etiology in diagnosing intellectual disability and details etiologic assessments and the multi-dimensional classification system
Overview of Children with Disabilities	Teaches how to recognize common developmental disabilities that require comprehensive medical and developmental assessments
Cognitive Behavioral Therapy (CBT) for People with Developmental Disabilities	Discusses the application of CBT for clients with intellectual and developmental disabilities, including assessment and treatment modifications
Crisis Intervention for Individuals with Developmental Disabilities	Provides an overview of managing crisis situations and teaching coping skills to people one supports
Medication Management for Individuals with Developmental Disabilities Part 1	Provides a basic overview of guidelines and terminology used in medication management

We also disseminate information about ADA requirements to help remind providers of their responsibility to ensure accessibility for all patients, as required by law. A variety of training and reference materials are also available on our Kentucky Medicaid website and through Availity.

a.iv.

Approach to ensure a comprehensive network to address the needs of all Enrollees, including the provision of services in a culturally sensitive and linguistically appropriate manner.

Humana is dedicated to cultivating a unique and diverse culture that is representative of the communities we serve. Our cultural competency framework is structured to empower our associates to collaborate with and learn from providers, community partners, and our Enrollees to understand and address culturally specific and unique barriers to health. We use associate, provider, and Enrollee insights to improve our business practices and services to make it easier for people to achieve their best health and personal definition of well-being. Collectively, we focus on three key priorities: (1) building a diverse and inclusive internal organization, (2) building a culturally humble and inclusive provider network, and (3) regularly assessing and acting upon Enrollees' needs.

INTERNAL FOCUS ON DIVERSITY, INCLUSION, AND CULTURAL HUMILITY

Promoting diversity and inclusion is woven into the fabric of our organization. Our ability to build deep relationships and create simple, personalized healthcare experiences for Enrollees requires a diverse set of perspectives. Our Executive Inclusion & Diversity Council leverages senior leadership to advance inclusion and diversity and set strategy for the entire organization. Chaired by our Chief Executive Officer, Bruce Broussard, the Council's top priorities include hiring, developing, and retaining a diverse workforce, creating an inclusive workplace, and implementing accountability to sustain outcomes internally and with our providers, community partners, and Enrollees.

Humana has been recognized as a leader in employing a diverse associate base, as evidenced by the following recognitions. These awards reflect Humana's objective to hire associates with a wide range of backgrounds and experiences, which helps us understand what it takes to build a provider network that is equipped to provide culturally humble care to our Enrollees.

In Kentucky, we employ CHWs as part of our care management team in Service Regions across the Commonwealth. Our goal is to hire CHWs who are representative of the communities they serve so they can leverage their community connections and cultural awareness to engage with Enrollees, help connect them to care, and navigate the healthcare system and community resources.

SELECTED HUMANA AWARDS & RECOGNITIONS



100% on Human Rights Campaign's
Corporate Equality Index for six
consecutive years



#4 of American's Most JUST
Companies, Capital & Robert Wood
Johnson Foundation's Top 100
Companies Supporting Healthy
Communities and Families



Mogul's Top 100 Innovators in
Diversity & Inclusion

DEVELOPMENT OF A CULTURALLY HUMBLE AND INCLUSIVE PROVIDER NETWORK

Partnerships with providers are critical to improve the health and quality of life for our Enrollees. This is particularly true for vulnerable subpopulations, such as those with low literacy levels or English Language Learners. We take a two-pronged approach to ensuring our network continues to meet the cultural, ethnic, racial, and linguistic needs of our Enrollees: (1) We have several written policies about our strategy for recruiting

and retaining providers who are representative of the communities we serve, and (2) we provide educational resources to our provider network focused on cultural competency and cultural humility—the practice of communicating and building relationships with Enrollees to understand their specific needs.

Humana’s current Kentucky Medicaid network providers have a diverse array of backgrounds and linguistic skills as shown in **Table I.C.18-2**; however, we recognize that the needs of our Enrollees change over time. Humana has processes in place to measure the ethnic composition of our membership, assess the linguistic and cultural needs of the population, and adjust the Provider Network to meet those needs. For example, much of eastern Kentucky rests in the Appalachian region, which has unique historical and cultural nuances that differentiate it and its residents from other parts of the Commonwealth, such as the urban Louisville area or rural western Kentucky. We have network providers, such as Appalachian Regional Healthcare, that specialize in caring for this population’s unique needs and in alignment with cultural preferences. Relatedly, in recognition of these needs, we are exploring partnership opportunities with a leading academic institution with expertise on Appalachian culture that can inform training materials for Humana associates and providers serving Appalachian Enrollees. Kentucky also has a significant refugee population, comprised largely of individuals and families resettling from the Democratic Republic of Congo and Cuba. Louisville has the largest number of refugees, though Bowling Green and Lexington have considerable refugee populations. While not all refugees are eligible for Medicaid, some are, and we recognize that their needs are unique. We have network providers, such as Home of the Innocents and Open Arms Children’s Health, to address these needs appropriately while being responsive to their cultural preferences.

Table I.C.18-2 Selected Languages Spoken by Providers in Humana’s Kentucky Medicaid Network

Afrikaans	Croatian	Hungarian	Nepali	Slovak
Albanian	Czech	Italian	Norwegian	Slovenian
Amharic	Danish	Japanese	Persian (Farsi)	Somali
Arabic	Dutch	Kannada	Polish	Swahili
Armenian	German	Kashmiri	Portuguese	Swedish
Bengali; Bangla	Greek	Korean	Punjabi	Tagalog
Burmese	Gujarati	Macedonian	Russian	Tamil
Cambodian	Hebrew	Malayalam	Serbian	Telugu
Chinese	Hindi	Marathi	Slovak	Thai

Humana requires providers to participate in educational training, which includes cultural competency, upon joining our network and annually thereafter. We also offer additional optional trainings (see **Cultural Fluency Training for Providers** text box). The mandatory orientation and annual educational training includes the following topics related to cultural competency:

- Training on policies and procedures for accessing language assistance
- Providing strategies for working with elderly or disabled Enrollees
- Working effectively with in-person and telephone interpreters
- Communicating with Enrollees with cultural and linguistic sensitivity
- Disseminating information on cultural differences and diversity within our membership

Cultural Fluency Training for Providers

Humana's Director of Experience, Strategy, and Transformation, Tony Suarez, leads cultural competency interventions by designing and implementing platforms to support our providers. For example, we have an ongoing partnership with the University of Louisville to conduct Continuing Medical Education (CME) classes on Cultural Fluency for providers. This CME class teaches providers about acculturation (the process for assimilating into a different culture), as well as how to build empathy for cultural and communication differences among ethnic groups. Sample topics include the cultural role of physical touch and how to affect behavior change while recognizing cultural differences. In 2019, we conducted three sessions per month for four months, reaching about 3,000 participants nationally.

ANNUAL ASSESSMENT OF ENROLLEE NEEDS

We use data aggregated from the Social and Economic Characteristics of the estimated Census Population and the Modern Language Association Language Map to understand the linguistic and cultural composition of the population. As new Enrollees are added, we take Enrollee growth and the geographic enrollment shifts into account to ensure adequate access to care, including linguistic and cultural needs to mitigate barriers to care. For example, we can translate our Enrollee information materials into the predominant languages spoken to address the linguistic needs of the Kentucky population. In addition, our Provider Directory identifies all languages spoken by each provider. The Provider Directory is available in English and Spanish.

We also analyze the cultural and linguistic needs of our Enrollees and their geographic concentration to ensure appropriate access. Humana strives to maintain a culturally humble and diverse provider network. We conduct an annual comprehensive analysis (our access and adequacy assessment) of the cultural and linguistic needs of our Enrollees and their geographic concentration to ensure appropriate access to culturally competent care. To identify and address health disparities, we will stratify our Healthcare Effectiveness Data and Information Set (HEDIS) results by age, race, ethnicity, gender, and zip code. We will share these insights with our network providers to inform their approach to service delivery for their patient panel. Additionally, we monitor Enrollee inquiries on an ongoing basis to ensure we can respond in a timely manner to any provider issues related to cultural and linguistic needs. All of our provider contracts contain language requiring providers to treat Enrollees without prejudice. Our Kentucky Medicaid Culture & Community Engagement Director, Bryan Kennedy, will monitor our adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to advance health equity and population outcomes in the diverse communities we currently serve throughout the Commonwealth and for those we aim to serve in the new Contract.

We also monitor Enrollee inquiries on an ongoing basis. **Humana is currently pursuing the National Committee for Quality Assurance (NCQA) Distinction in Multicultural Health Care.** NCQA awards Distinction in Multicultural Health Care to organizations that meet or exceed standards in providing culturally and linguistically appropriate services. NCQA evaluates how well an organization complies with standards for collecting race, ethnicity and language data, providing language assistance, cultural responsiveness, quality improvement of CLAS, and reduction of healthcare disparities.

As Enrollee needs are identified, Humana analyzes the adequacy of the provider network in addressing the cultural and linguistic needs of Enrollees by conducting activities including:

- Collect data of languages spoken by the provider during credentialing and re-credentialing processes
- Recruit providers through referrals from minority organizations and associations
- Evaluate on annual basis the cultural and linguistic services being provided and ensure compliance with the Cultural Competency Plan
- Include Enrollee's expressed language preference as a factor in our PCP assignment algorithm

a.v.

Strategies the Vendor will implement to ensure the network adequacy and access standards are met if actual Enrollment exceeds projected Enrollment.

Humana will ensure we meet access standards if actual enrollment exceeds projected enrollment. Humana's Kentucky provider network currently provides access to care to more than 900,000 Enrollees across all of our lines of business. Our current Enrollee-to-PCP ratio in our Medicaid network is approximately 33:1. Even at a ratio of 200:1, our network can support more than 800,000 Medicaid Enrollees (approximately 883,200) which is about six times the size of our current Medicaid membership (more than 145,000). We are confident Enrollees will have access to all Covered Services if our enrollment exceeds projections.

Humana's Kentucky network providers currently serve Enrollees across all our Medicare and Commercial product lines of business, including the Medicaid population. Our networks can support significant enrollment growth because of our longstanding provider partnerships across multiple product lines. From our experience in Kentucky Medicaid, many new Enrollees select Humana based upon our robust network, allowing continuity of care with their current providers. For these Enrollees, the added enrollment creates little or no capacity strain on our existing network of providers. We have many features in place to ensure continuity of care for new Medicaid Enrollees. Facilitating continuity of care with previous providers is essential for the Enrollee, contractually required, and valuable in pursuing an in-network partnership with the provider and a positive relationship with Enrollees.

Humana conducts multiple analyses outlined below in **Table I.C.18-3**, to ensure that our delivery system continually meets and exceeds adequate capacity to accommodate existing and anticipated Medicaid enrollment, as well as to serve Enrollees effectively in the event of a large enrollment influx.

Table I.C.18-3 Network Adequacy Analyses

Analysis	Description	Frequency of Analysis
Geographic mapping (GEO) for travel distance access standards	Humana uses GEO networks to map membership to provider locations, measuring both distance and travel times. We analyze access for each provider specialty by Enrollee as indicated by the provider type.	Quarterly
Enrollee surveys	Humana reviews Consumer Assessment of Healthcare Providers and Systems (CAHPS) and BH Enrollee satisfaction survey results to identify any access to care issues.	Annually
Panel reports	Humana monitors PCP panel status to identify closed panels. Upon identification of a closed panel, we generate GEO network reports to assess the impact.	Monthly
Provider Relations visits	We use information from our provider site visits to assess referral needs and accessibility. Humana conducts these visits for PCPs and high-volume specialty physicians.	PCPs: Quarterly High-Volume Specialists: Quarterly
Grievances	Our MSRs forward Enrollee and provider grievances that reflect access problems to the Provider Network team for review.	Ongoing
Claims Data	Insights from claims data can serve as an early identification of access issues.	Ongoing
Out-of-network (OON) referrals	We track and trend OON referrals made by the care management and utilization management to identify potential network gaps.	Daily

Table I.C.18-3 Network Adequacy Analyses

Analysis	Description	Frequency of Analysis
Cultural and linguistic needs	Humana analyzes the cultural and linguistic needs of our membership and the geographic concentration of these Enrollees to ensure appropriate access.	Annually
Associate, provider, Enrollee, and advisory input	We examine anecdotal information from various internal and external sources as it pertains to network adequacy, including information contributed by individuals and committees.	Ongoing

Network Development Processes to Accommodate Additional Enrollment

In the event our enrollment increases and nears or exceeds capacity unexpectedly, we will follow the steps below to ensure our provider network can accommodate the expanded enrollment:

- Leverage our existing Commercial and Medicare networks for providers who do not currently participate in Medicaid to add the Medicaid line of business
- Identify additional PCPs in Service Regions for the increased enrollment and extend participating Medicaid agreements
- Incentivize PCPs to participate with Humana by offering VBP programs that reward them for quality outcomes and increased reimbursement for after-hours appointments to increase accessibility
- If we identify a provider specialty gap in a Service Region, or if there are no providers available in the required geographic radius, Humana will use other referral sources when appropriate. These approaches can include the use of telehealth services or the arrangement of transportation to the closest available provider when they are outside of the time and distance standards identified in the Draft Medicaid Contract.
- In the absence of a contract, we will work with non-participating providers through single case agreements. Humana will ensure that all necessary Covered Services are provided and will use non-participating providers for as long as the care cannot be supplied by an in-network provider. When we use single case agreements, we seek to contract with these providers to bring them into our network.

b.

If Subcontractors will provide Covered Services, describe how network development efforts will be coordinated with the Vendor's provider network development strategy and how the Vendor will monitor the Subcontractor's activities and ensure transparency of these activities to the Department.

Humana's overall network development strategy prioritizes creating simplified, integrated experiences for Enrollees. To minimize complexity, Humana utilizes a limited number of Subcontractors to provide Covered Services, preferring to instead provide or arrange Covered Services directly. By fully integrating BH and pharmacy services, Humana ensures the integrity and transparency of these data meet the high standards set by our Data Governance Leadership Council, and as a result significantly reduces response times to the Department for Medicaid Services' (DMS) regular and ad hoc requests. Of note, this will ensure full transparency and responsiveness of Pharmacy Benefit Management (PBM) reporting in accordance with 2018 Senate Bill 5 reporting requirements.

Where appropriate, we engage high-quality Subcontractors to provide Covered Services and manage the relationships with oversight policies and procedures to ensure we deliver only the highest-quality care to our

Humana's Network team directly manages our BH provider network, and Humana Pharmacy Solutions manages our pharmacy benefit services and network. Working together ensures seamless transfer of data, full transparency with direct submissions, and immediate follow up on supplemental data requests.

Enrollees. Based on our assessment of needs in Kentucky and Subcontractor capabilities in meeting those needs, we identified Avēsis (vision and dental) and Tivity Health, Inc. (chiropractic services) as meeting our rigorous standards for providing care to our Humana Enrollees. Humana has also contracted with two telehealth providers, MDLIVE and Arcadian Telepsychiatry, to provide services to Enrollees. Because these telehealth Subcontractors have direct contact with Enrollees and provide mostly Covered Services, Humana applies the same standards, policies, and procedures to these Subcontractors as traditional “brick and mortar” subcontracted providers, such as Avēsis and Tivity Health, Inc.

SUBCONTRACTOR NETWORK OVERSIGHT AND COORDINATION

To ensure that each Subcontractor adheres to requirements and meets expectations, Humana has implemented a rigorous oversight program. This Subcontractor oversight program assigns corporate and market-based teams responsibility for Subcontractor performance to ensure Subcontractors comply with all provisions of the Kentucky Draft Medicaid Contract and with their own services agreements with Humana.

Humana’s unique corporate-local structure also results in a multi-layered approach to oversight of Subcontractors. At the corporate level, we have established national Subcontractor and delegation policies and procedures to ensure consistency across our organization. This includes our Compliance Policy for Contracted Organizations that details our goals and expectations, which we provide to all Subcontractors and incorporate into our contract terms and conditions. In the Commonwealth, our local executive leadership, led by our Kentucky Medicaid CEO, Jeb Duke, oversees the operations and performance of our Kentucky Subcontractors on a day-to-day basis. To ensure compliance with Contractual obligations and regulatory requirements, Humana maintains a Kentucky-based Subcontractor Oversight Committee and Subcontractor Performance Oversight team. The Subcontractor Oversight Committee, in conjunction with Relationship Managers assigned to each Subcontractor and market and compliance leadership, is dedicated to overseeing delegated functions, including but not limited to network monitoring functions.

Life Cycle of a Subcontractor Relationship

Prior to contracting, we carefully evaluate potential Subcontractors, using a strategic and competitive six-step procurement process. This includes (1) internal and (2) external cost analysis to optimize savings opportunities; (3) a sourcing process that includes competitive bidding; (4) contract negotiations; (5) implementation to ensure every potential partner satisfies all commercial, legal, and compliance standards; and (6) ongoing monitoring and oversight, which includes all assessments and audits required by both regulation and Draft Medicaid Contract at the time of functional delegation. We include a strong due diligence and screening process as part of these six steps.

Due Diligence: We have in place a standardized process to ensure compliance with our contracting protocols, as well as applicable legal and risk management requirements. Our Operational Risk Management team records all new relationships in a centralized repository that details Subcontractors’ relevant information and any risk ratings.

Screening: Our screening process includes an extensive review of Subcontractors’ financial viability and eligibility to participate in federal and State healthcare benefit programs. Specifically, our associates check all relevant databases to ensure Subcontractors have a valid license to provide services and that these individual Subcontractors, their owners, and their executives have not been suspended, excluded, or debarred from participating in a Kentucky or federal healthcare program.

Contracting: Following our rigorous screening, Humana executes contracts with each Subcontractor that fully describe all services to perform, all reporting and metrics to track, and all service levels to meet. Humana establishes written performance standards with each Subcontractor that address requirements of the Commonwealth’s Draft Medicaid Contract, as well as additional standards that Humana tracks, to ensure the highest level of performance to specific needs of the service. This includes responsiveness to information

requests for both content and timing, as well as the provision of complete and accurate information to allow Humana and DMS to implement a comprehensive oversight process.

Pre-Delegation Audit: The Delegation Compliance department performs a pre-delegation audit prior to any core function being delegated to a Subcontractor. The pre-delegation audit includes evaluation of a prospective Subcontractor's compliance and performance capacity against State, federal, accreditation, and Humana standards. This includes a review and approval of things, such as policies and procedures, program descriptions, forms, tools, data and reporting capabilities, proof of accreditation, the U.S. Department of Health and Human Services, Office of the Inspector General federal System for Award Management (SAM), Preclusion List, and other Federal/State exclusion screenings.

Implementation and Onboarding: Our Subcontractor onboarding process includes sharing relevant documents (e.g., contracts, credentialing information, forms, etc.), data exchange set up, system testing, and establishment of metrics and reporting requirements. We also require that Subcontractors' staff complete the same mandatory training as our associates within 30 days (and annually thereafter) related to applicable CMS and/or Medicaid requirements. This training includes information about our Standards of Conduct, program integrity requirements, and cultural competency, among other topics. Humana automatically terminates access to Humana systems if this training is not completed. During onboarding, Humana assigns each Subcontractor a Relationship Manager, discussed below.

Kentucky Medicaid Training: Along with Humana's required training, Subcontractors in Kentucky are required to complete a Kentucky Medicaid Contract-specific training at the beginning of the Contract period (or the beginning of their subcontract with Humana). This training details the requirements of the Kentucky Medicaid program and the Draft Medicaid Contract requirements.

Ongoing Subcontractor Oversight and Monitoring: Ongoing monitoring and oversight involves a wide range of activities performed across our business operations. **Wesley Whitmire, our Director for Medicaid Market Development, leads our ongoing risk monitoring on a day-to-day basis. He is supported by our local, Kentucky-based associates to whom we refer as our First Line of Defense in our Enterprise Risk Management (ERM) program.** We assign a Relationship Manager to each Subcontractor who serves as the key point of contact between the Subcontractor and Humana. Relationship Managers are responsible for the Subcontractor relationship maintenance and management of performance pursuant to policy and in coordination with Kentucky market operations and all key constituents.

Relationship Managers oversee and monitor the performance of their assigned Subcontractors via regular joint operational meetings with the Subcontractor and receipt of regular reporting (as required in its Subcontract with Humana and in accordance with the Contract). These Joint Operating Committee (JOC) meetings are designed to review the previous period's Subcontractor performance as compared to service level agreements that define performance requirements and their subcontract provisions. The Relationship Manager leads JOC meetings, which include engagement by key Commonwealth market operations and Subcontractor personnel. We invite the leader responsible for Subcontractor oversight performance, along with other business, operations, and compliance team members of both parties as well. The JOC meetings also provide a forum to review the Subcontractor's contractual compliance in areas such as data transfer and validity and performance metrics such as network access and adequacy and appointment time standards.

Along with our First Line of Defense associates, Humana's Third Party Risk Management team, which is a corporate level team and serves as our Second Line of Defense in our ERM program, assists our local Subcontractor oversight associates who operationalize our Subcontractor Performance Oversight function and monitor performance across all Kentucky Subcontractors. These teams use several point-in-time and forward-looking metrics to track performance, risk exposure, and maintain transparency in decision-making. The reports are used to assess:

- Subcontractor performance
- Opportunities for improvement
- Progress in addressing corrective actions
- Opportunities to maximize value

Summaries of Subcontractor performance reports are reviewed at periodic Subcontractor Oversight Committee meetings. The Kentucky Subcontractor Oversight Committee consists of our:

- Subcontractor Performance Oversight team and Third Party Risk Management
- Kentucky Medicaid Chief Operating Officer Samantha Harrison
- Relationship Managers
- Network Contracting leaders including our Provider Network Director, Majid Ghavami, and Provider Services Manager, Michelle Weikel
- Kentucky Medicaid Medical Director Lisa Galloway, MD
- Regulatory Compliance Officer Kimberly Myers
- Representatives from operational areas within the plan

We also collaborate closely with our Subcontractors through regularly scheduled JOC meetings where we review a range of functions including claims, clinical management, compliance, and Enrollee Services, allowing us to assess network adequacy through a variety of avenues. JOC will also review concerns related to grievances and appeals, Enrollee satisfaction, and Subcontractor network adequacy that emerge from different channels, such as Enrollee complaints, and will organize a plan to address the issue with the Subcontractor.

Subcontractor performance reports and Subcontractor Oversight Committee minutes are also presented to the Kentucky Medicaid Quality Improvement Committee (QIC). Matters meriting broader engagement are presented to the Executive Steering Committee. For any deficiencies found during onboarding or ongoing monitoring, our Relationship Managers develop a remediation plan to mitigate the risks. This plan may include issuance of a corrective action plan, Issue and Opportunity Plan (IOP) more frequent meeting, increased oversight, and/or a path for escalation.

MONITORING OF NETWORK REQUIREMENTS

For Subcontractors that provide Covered Services to Enrollees, such as Avēsis and Tivity Health, Inc., Humana requires our Subcontractors to provide an initial network development and monitoring strategy and subsequent network data on a monthly basis after the start of the program. We analyze the data against our adequacy standards to identify any issues. Our Relationship Managers and Subcontractor Oversight team review reported metrics for performance standards with Subcontractors on a prescribed cadence, typically monthly, and take immediate action, when necessary, when there is a delay or failure to respond to DMS information or reporting requests. Any identified failure to meet a standard is subject to development, implementation, control, and closure of a corrective action plan, as well as monetary penalties for each failure. Continuous failures or lack of improvement can also result in revocation of delegated functions and/or termination of the Subcontractor relationship.

Annual Evaluation: As part of our Subcontractor oversight program, the Third Party Risk Management team completes a self-evaluation annually, with feedback by corporate and market leadership, to ensure it remains current and relevant including the program structure, scope, and effective leadership involvement. For Subcontractors providing Covered Services, evaluation of performance metrics related to network composition,

access and adequacy standards, and quality of care are included in this annual evaluation. The evaluation and any enhancements are used to refresh the Program description documentation.

Humana's Regulatory Compliance team also conducts annual audits related to the relationship management process for Medicaid Subcontractors to assess compliance with policies and procedures and review evidence of Subcontractor oversight. Reviews include evidence of training attendance, documentation of operational meetings, consistent and timely submission of performance and metric reporting, and participation in Subcontractor audits and the corrective action plan process.

Data Integration and Transparency: We clearly state our data and reporting expectations in our agreements with our Subcontractors. Our Subcontractor agreements incorporate Service Level Agreements that define additional performance expectations. These agreements also require that Subcontractors adhere to the performance requirements included in the Draft Medicaid Contract and DMS' policies, procedures and expectations. Through Humana's Subcontractor agreements, Subcontractors are required to submit data sufficient for Humana's oversight and monitoring, as well as DMS' oversight of Humana. Humana requires data transparency; data must be reliable, accurate, timely, and actionable with clear visibility into the source. Humana puts a corrective action plan in place with Subcontractors that fail to provide the required data that are accurate, transparent, and timely.

In our Service Level Agreements with our Subcontractors, we describe specific penalties for not complying with data and reporting requirements. For example, our Service Level Agreements with Subcontractors transmitting encounters include the following terms:

- Encounter Data File Timeliness: Failure to deliver an encounter file meeting agreed-upon specifications within the times specified will result in a charge of \$1,000 per late submission per calendar day
- Encounter Data Accuracy: An error rate greater than five percent in encounter data received from a Subcontractor based on a Humana encounter response file will cost \$1,000 per file that exceeds the standard of more than five percent errors
- Encounter Data Completeness: We require a completeness rate of at least 90% in encounter data received from a Subcontractor based on a Humana encounter response file; the fee is \$1,000 per file that does not meet the standard for completeness rate
- Encounter Data File Transfers: Files must be transferred no later than Friday 12:00 A.M. (midnight) Eastern Standard Time (EST); the fee is \$100 per late file per calendar day
- Encounter Data Corrections: Within 30 calendar days after notice by Humana of encounters/claims failing X12 (EDI) or Humana edits, Subcontractors must correct all encounter/claim records for which errors should be remedied and resubmit to Humana. The fee is \$1,000 per late resubmission per calendar day after 30 days. A resubmitted file with uncorrected errors is not considered to be timely resubmitted.

[REDACTED]

Reporting and Ad Hoc Analysis: Subcontractor encounter data are fed into our Enterprise Data Warehouse (EDW) on a daily basis and are aligned with other data to create a comprehensive, person-based, longitudinal record on each Enrollee. Due to the integrated nature of our EDW, we are able to derive additional insights that enhance our reporting and analysis. For example, integration of pharmacy interactions with medical claims and encounters allows us to understand patterns of medication adherence for those with chronic conditions such as hypertension. Similarly, data feeds from vision care providers, such as ophthalmologists, integrated with other medical claims can help us determine if those with diabetes are receiving needed vision care.

Integration of data into our EDW and report generation processes supports routine reporting such as HEDIS and enables other ad hoc analysis that may lead to clinical interventions, population health approaches, or enhancements to benefit design. Humana's Medicaid Reporting and Data Analytics team integrates Subcontractors' data with Humana's performance data to allow for a full, complete, and transparent view of Humana's network operations for DMS's oversight and monitoring.

c.

Describe the Vendor's approach to use telehealth services to improve access. Include the following at a minimum:

Telehealth is a core component of Humana's strategy to ensure our Enrollees can access the right care at the right place at the right time. We view telehealth as a powerful tool to help bring additional access to urgent care, specialty, and BH services to our Enrollees, particularly those who live in rural and underserved urban areas. Our overarching telehealth strategy, which we will discuss in greater depth throughout this section, includes the following key components:

- Partnering with provider organizations that have existing telehealth capabilities to expand the reach of those services into communities
- Offering practices the opportunity to integrate telebehavioral health services into their practices through our partnership with Arcadian Telepsychiatry
- Providing our Enrollees with direct access to innovative digital and virtual health solutions, including partnerships with MDLIVE and Pacify
- Leveraging telehealth technology to help providers learn from and connect with their peers
- Providing resources and education to practices to help them transform their practices to include telehealth services and understand relevant coverage and billing procedures
- Reimbursing consulting providers at parity with similar in-person services in accordance with the Kentucky Medicaid fee schedule or through VBP arrangements.

At the end of 2019, the Kentucky Telehealth Program of the Cabinet for Health and Family Services invited Humana leaders to participate in various workgroup to assist the Kentucky Telehealth Program advance telehealth efforts throughout the Commonwealth. Workgroup topics include school-based physical and behavioral health, privacy and compliance, workforce education and outreach, and SUD treatment. The first round of workgroups is scheduled to begin in February 2020. Humana is honored to participate in these sessions and looks forward to supporting the Kentucky Telehealth Program's mission and objectives.

In May 2019, Humana's Kentucky Medicaid CEO, Jeb Duke, attended the Kentucky Telehealth Summit sponsored by the Kentucky Office of Rural Health. Mr. Duke presented Humana's vision of telehealth, reaffirming our commitment to access and payment parity. He also emphasized Humana's dedication to **advancing traditional providers' entrance into telehealth through joint investment, technology support, and education.**



INCREASING TELEHEALTH SERVICES AVAILABLE IN PROVIDERS' OFFICES

Humana is working with practices to increase their capabilities to offer telehealth services onsite. We believe that offering our Enrollees access to virtual specialty and BH services in physician offices will increase timely access to services and promote continuity of care in a safe and trusted environment. We provide practices with practice transformation support to help them integrate telehealth services into their clinical workflows. Additionally, we have also partnered with Arcadian Telepsychiatry to increase access to BH resources in primary care practices.

Arcadian Telepsychiatry: Humana has partnered with **Arcadian Telepsychiatry** to provide Humana Enrollees with access to a broad network of licensed and credentialed psychiatrists, psychologists, and other BH therapists. These providers collectively offer a full suite of BH and wellness services, including short-term (urgent), medium-term (rehabilitation) and long-term (management) behavioral care. Arcadian's telehealth model is optimized to deliver BH care, offering unprecedented access to BH services, particularly in areas of the Commonwealth where there are provider shortages and limited in-person services available.

The technology for scheduling and videoconferencing is set up inside a PCP's office and is accessible through a secure portal, creating a seamless experience for the patient, referring physician, and Arcadian provider. The services include initial and follow-up psychiatric evaluations and diagnoses, medication prescribing and monitoring, doctor-to-doctor consultations, therapy, and ongoing treatment. Arcadian works closely with PCPs, deploying telepsychiatry as an integrated service into their practices, improving accessibility, reducing wait times, and enhancing patient engagement.



Example of an onsite telehealth consultation room

BRINGING DIGITAL HEALTH TOOLS DIRECT TO ENROLLEES

Many Enrollees prefer to access services and health-related resources through their phones, computers, or other devices. Humana has partnered with MDLIVE and Pacify to bring telehealth and digital solutions directly to our Enrollees. While these solutions do not replace in-person care, they can help Enrollees more easily access virtual services and resources to help them better manage their health without the need to miss work or school, find childcare, or navigate transportation.

MDLIVE: We will utilize the **MDLIVE** virtual care platform to offer our Kentucky Medicaid Enrollees telehealth capabilities aimed at reducing ED visits. Enrollees will have access to 1) **Medical Virtual Visits** through which they can access licensed healthcare professionals for diagnosis and treatment of common non-emergency illnesses, 2) **BH Virtual Visits** through telebehavioral health and telepsychiatry where Enrollees can see a licensed therapist or board-certified psychiatrist face-to-face from the comfort of their home, and 3) **Primary Care Virtual Visits** to address follow-up care needs between visits with Enrollees' PCPs and to access primary care for healthcare needs. All MDLIVE providers providing telehealth services to our Kentucky Enrollees are required to be a licensed Kentucky Medicaid provider in good standing and comply with the telehealth participation criteria described in our response to sub-question I.C.18.c.i below.



MDLIVE Mobile App

The MDLIVE platform and related applications allow patients and providers to access a secure virtual care environment via web and native mobile applications. The platform's video solution supports up to 64 video interactions simultaneously and has features that support real-time sharing of data, including images, videos, and information captured from medical devices. Additionally, MDLIVE's platform and applications can be integrated with the leading EHR systems, including the Kentucky Health Information Exchange (KHIE) and patient portals. These integrated capabilities enable providers to support on-demand and scheduled virtual care as part of their workflows, and enables patients to request and confirm telehealth visits.

Pacify: Our partnership with **Pacify** gives pregnant women access to physician extenders 24 hours a day, seven days a week (IBCLCs, RNs, and others) using a proprietary, video-enabled call-routing system that activates statewide provider networks. The technology connects a pregnant Enrollee to a live resource within 30 seconds or less, providing access to services at acute moments when the ED is often the only available alternative. This mobile application also provides Enrollees with information about their pregnancy benefits, as well as timely nudge notifications regarding prenatal visits, vaccines, postpartum visits, and other milestones.

LEVERAGING TELEHEALTH TECHNOLOGY TO SUPPORT PROVIDER EDUCATION AND CONSULTATIONS

Technology is critical to enabling the equitable diffusion of clinical knowledge and evidence-based practices, particularly amongst medical professionals serving patients in rural and underserved locations. Humana is eager to support providers to communicate with and learn from one another through provider-to-provider consultations and educational forums. Humana will offer a psychiatric consultation service for PCPs and OB/GYNs offering care to our Kentucky Medicaid Enrollees. Through this service, providers can receive a consultation from a psychiatrist, equipping them to deliver BH services in line with their professional licensure, including systematic and evidence-based screenings and treatment for mild or moderate BH conditions (including medication management, as appropriate), without further referral. Additionally, Humana is exploring opportunities to partner with leading academic institutions to launch Project ECHO™ programs focused on critical areas of educational need, such as TIC, BH, and maternal child health. Project ECHO™, originally developed in Albuquerque, New Mexico, is a model that uses interactive video technology and de-identified clinical cases to allow providers to learn from, consult with, and mentor each other on a particular clinical area. The goal is to better equip providers, particularly those in rural areas, to care for complex patients appropriately and effectively in settings close to their homes and communities. We will encourage our network providers to join a Project ECHO™ program that suits their needs and interests.

c.i. Criteria for recognized sites.

Whether face-to-face or through web-based technologies, Humana is committed to providing our Enrollees with access to safe, effective, and high-quality care. In an effort to promote telehealth broadly across the Commonwealth, Humana aligns our requirements for consulting and presenting sites, as well as reimbursement for services delivered via telehealth, with Kentucky's administrative code. Additionally, we are working to increase the number of practices and community locations serving as telehealth presenting sites; Humana applies several criteria to target our efforts.

CONSULTING AND PRESENTING SITE REQUIREMENTS

Humana aligns our requirements for telehealth consulting sites with Kentucky's current administrative code, 907 KAR 3:170 and all related regulations referenced therein. As such, we reimburse providers delivering telehealth services from consulting sites at parity with similar in-person services provided they are:

- Enrolled as a Medicaid provider in accordance with 907 KAR 1:672
- Participating as a Medicaid provider in accordance with 907 KAR 1:671
- Operating within the scope of their professional licensure
- Operating within their scope of practice

- Delivering medically necessary services
- Able to meet all other requirements promulgated by this regulation and State law, including patient confidentiality standards and timely medical record documentation

We apply the same rigor to monitoring telehealth services as we do for traditional, in-person services. Our provider contracts contain the same high standards and service criteria regardless of whether the service is rendered through telehealth platforms or in-person visits.

Humana also aligns our criteria for presenting sites with 907 KAR 3:170 and allows our Enrollees to access telehealth services in their homes, schools, communities, and providers' offices. Humana's partnerships with MDLIVE (a telehealth platform offering Enrollees access to urgent care and BH providers from their smartphones, computers, or other devices) and Pacify (a mobile application offering pregnant Enrollees access to physician extenders and pregnancy resources) allow Enrollees to access services wherever is most convenient for them.

Targeting Telehealth Resources to Areas of Greatest Need

Beyond reimbursing for telehealth services, Humana is committed to helping increase the number of practices and community locations with telehealth capabilities. We believe this is especially important as some of our Enrollees may have limited access to smartphones, data, and/or WiFi, be housing insecure or homeless, feel unsafe where they live, or simply have personal preference to go to a practice or community location for telehealth services. Humana has partnered with Arcadian Telepsychiatry, a national partner, as well as Kentucky-based providers, such as Norton Healthcare, to increase the number of practices and community locations that can serve as telehealth presenting sites.

- **Arcadian Telepsychiatry** provides Humana Enrollees with access to a broad network of licensed and credentialed psychiatrists, psychologists, and other BH therapists. These providers collectively offer a full suite of BH and wellness services, including short-term (urgent), medium-term (rehabilitation) and long-term (management) behavioral care. Arcadian's technology for scheduling and videoconferencing is set up inside a PCP's office and is accessible through a secure portal, creating a seamless experience for the patient, referring physician, and Arcadian provider. When considering which practices to target to serve as Arcadian presenting sites, Humana considers two main factors: community need and provider interest and capabilities. We start by conducting thorough demographic research to identify the towns, counties, and Service Regions where our Enrollees live that have the most severe need for BH resources. We then conduct outreach to those providers to understand their current practice capabilities (e.g., room to host telehealth visits) and interest.
- After identifying a need to bring access to care to school-aged children, Humana partnered with **Norton Healthcare** to support the advancement of Norton Healthcare's school-based telehealth program in Jefferson County Public Schools. Humana will sponsor the telehealth technology that Norton Healthcare uses to remotely examine the student with the assistance of the school nurse. By creating telehealth presenting sites at Jefferson County Public Schools, we will be able to reduce disparities in access to care for children in an underserved area while improving the overall health of the community.
- To expand dental care access to our Enrollees in underserved provider shortage areas, we will use Avēsis' tele-dentistry service. **Tele-dentistry expands access to dental services for Enrollees who, for example, live in rural areas without a sufficient supply of dentists or limited access to transportation.** In partnership with the KPCA, Avēsis will pilot tele-dentistry in Kentucky through selected FQHC and RHC partners. We plan to include collaboration with local health departments in the pilot to engage public health hygienists in delivering virtual care.

c.ii. Education efforts to inform providers and Enrollees.

Humana ensures our provider network and our Enrollees receive substantial education designed to address their varying knowledge bases, as well as increase utilization and access to covered telehealth services, through accessible and convenient modalities. We are educating providers and Enrollees about telehealth coverage, its benefits, and how to engage with these services using the following strategies:

Provider Education

Many providers have expressed challenges with navigating telehealth coverage, reimbursement, and other requirements across payers' Commercial, Medicare, and Medicaid products. Humana's telehealth educational materials clearly communicate to providers that Humana reimburses for telehealth services and references the Provider Manual for additional details on billing the correct modifying code and following regulatory requirements. Additionally, Humana offers extensive provider education and training about telehealth services:

- General education: Humana's Clinical Product team offers trainings to network providers regularly, as well as internal clinical and call center associates, on our telehealth coverage, reimbursement, and how to use MDLIVE and Arcadian technology. Additionally, we have developed web-based trainings tailored to different groups (e.g., providers, clinic staff, and internal Humana associates). Accessible at any time, these trainings provide overviews on Humana's telehealth benefits, how to utilize telehealth services from our national partners, and how to educate patients/Enrollees about available telehealth services. These clear and accessible resources help providers feel more confident in referring Enrollees to MDLIVE, Arcadian, or other locally available telehealth services.
- Training and coaching to set up Arcadian technology: For practices opting to implement Arcadian Telepsychiatry technology, Humana and Arcadian will work directly with each practice to coach providers on how to use the technology, integrate the telehealth platform into the practice's day-to-day operations, and share best practices on working with consulting Arcadian providers to best coordinate care for their patients. Humana's Clinical Product team has also developed resources for our network providers to help them drive appropriate utilization to these telepsychiatry and telebehavioral health services.
- Practice Transformation Support: All network practices have access to practice transformation support through our Provider Relations team, led by Michelle Weikel, our Kentucky Medicaid Provider Services Manager. Our practice transformation resources help providers feel comfortable offering and making referrals to telehealth services. First, under our PTI program, eligible practices can receive financial support to offset the costs associated with implementing telehealth technologies. Second, Humana's Provider Relations team includes a Practice Innovation Advisor who provides practices with specialized operational and clinical transformation support. This individual is available to consult with providers on ways to advance their practice, including adoption of telehealth technology and the most effective ways to utilize the funding from the PTI.

Enrollee Education and Outreach

We focus on creating personal, simple, connected experiences to help Enrollees and their families understand how to successfully navigate the healthcare system and make educated decisions to improve their health outcomes. Our approach to Enrollee education and outreach incorporates the requirements of Section 22 of the Draft Medicaid Contract and are summarized below.

The central goal of our outreach and education is to ensure Enrollees have access to high-quality care to improve their health and well-being. We educate Enrollees on telehealth benefits and how to access these services, as well as target outreach to each Enrollee through our Member Services Call Center and care management teams.

We develop and disseminate education materials such as our Enrollee Handbook, which includes a description of Covered Services and is available to Enrollees upon enrollment. It is also available online and delivered to Enrollees within five business days of enrollment. We also develop and disseminate our Provider Directory,

which includes key information about how to navigate the healthcare system and access services. Along with our Enrollee Handbook, Enrollees may also access information about Covered Services through the MyHumana Enrollee Portal and mobile application (e.g., electronic ID card, Physical Finder Plus). We also periodically send newsletters to Enrollees about availability of specific Covered Services and how to access them (e.g., telehealth services, flu vaccinations, and preventive screenings). We also conduct call campaigns aimed at providing information about Covered Services. Our state-of-the art technology platforms deliver proactive, personalized messaging targeted to Enrollees' needs. This education also evolves over time as we progress with them through their personal health and well-being journey.

Humana's internal care management and call center associates frequently interact with our Enrollees, and we utilize these interactions to educate our Enrollees about available benefits and resources, including telehealth, that can help engage them in their care and close any care gaps. Humana conducts regular live and web-based educational sessions with our internal Enrollee-facing associates (e.g., CMs, CHWs, Member Services call center associates) to ensure that they are able to help Enrollees understand their telehealth benefits and how to access them. As a result, our CMs are able to target outreach to our Enrollees in care management to educate them about MDLIVE's primary care, urgent care, and telebehavioral health capabilities to address their non-emergent needs and/or help close any care gaps. Our CMs are able to directly enroll them in MDLIVE to facilitate access. We have found that Enrollees are more likely to join MDLIVE if their CM offers to do so directly. In addition to helping Enrollees access MDLIVE's direct-to-enrollee platform, we maintain a database of providers equipped with telehealth capabilities, including those participating in our Arcadian Telepsychiatry partnership. Our clinical and enrollment associates can access this information to help our Enrollees navigate accessing telehealth services in providers' offices.

c.iii.

Whether reimbursement will be available to the presenting site as well as the consulting site or only the consulting site. Include any requirements or limitations on reimbursement.

Humana understands that in order for telehealth to truly be impactful in increasing access to care it must be financially sustainable for providers. Humana reimburses consulting site providers delivering telehealth services at a minimum of 100% of the amount paid for comparable in-person services, in alignment with 907 KAR 3:170.

[REDACTED]

[REDACTED]

c.iv.

Lessons learned and successes or challenges with implementation of telehealth services for other programs the Vendor has served and that the Vendor will consider for provision of telehealth services in Kentucky.

Humana's experience building telehealth capacity in Kentucky and other states has given us a keen understanding of potential barriers to telehealth adoption, as well as potential innovative solutions. By taking a proactive and broad approach to addressing these barriers and capitalizing on opportunities, we have been able to utilize telehealth to expand access to specialty and BH care, increase the opportunity for detection and management of chronic conditions, and improve overall health outcomes.

Challenges

Though we have successfully implemented and enhanced telehealth within our Medicare, Medicaid and Commercial markets, we have identified various challenges that we continue to proactively address.

- Enrollee awareness: Utilization of telehealth in our Medicare line of business has been lower than expected due to Enrollees delaying their initial registration on the telehealth platform, which prevents the telehealth provider from promoting telehealth services directly to the Enrollee
- Barriers with technology: While recent studies have found that 86% of the adult Medicaid population own smartphones, Enrollees still face challenges with telehealth technology.¹ Some Enrollees need help installing telehealth mobile applications and others have concerns about the cost of associated data usage.
- Barriers for Enrollees with Physical and Mental Disabilities: Enrollees with physical and mental disabilities and BH issues have expressed ease-of-use challenges with accessing telehealth services
- Data sharing: Issues with data sharing have prevented Enrollee care teams and PCPs from accessing patient information following a telehealth visit
- Practice Workflow Redesign: Implementing telehealth solutions in practices necessitates commitment of both physical space to hold the visits and staff to assist patients. Practice operational and clinical leadership, as well as clinical and non-clinical staff, need to be committed and change their workflows to make telehealth successful.

Lessons Learned and Successes

Drawing upon our experience and identification of telehealth implementation challenges, we have developed solutions that have been implemented for our Medicare and Medicaid programs that we will seek to incorporate in Kentucky.

- Facilitated Training: Members of our Clinical Product team go onsite to train providers on how to register and refer Enrollees for telehealth services. Provider feedback has been positive, and the training has increased Enrollee registration and referrals. Additionally, for providers with Arcadian Telepsychiatry integrated into their practices, our Clinical Product team and Arcadian work directly with providers to train them on how to use the technology, when to refer patients, and how to best coordinate with Arcadian providers.
- Practice Transformation Support: To help providers overcome resource constraints when transforming their practices, Humana offers both financial and in-kind support. Eligible practices can qualify for the PTI, which can support strategic investments to promote practice transformation, such as purchasing telehealth technology or redesigning clinical workflows. If our provider partners are granted this incentive, our Practice Innovation Advisor collaborates with providers to maximize its potential reach.
- Direct-to-Enrollee Care: Successful outcomes with our Medicare telehealth initiative include real-time urgent care visits with an average wait time of 12 minutes and decreasing BH visits from 37 days (on average) to approximately 10 days, with roughly 75% of Enrollees completing their visits. We have also found that once Enrollees utilize this platform, they become repeat users. These outcomes set the stage for success in Medicaid as well.

¹<https://www2.deloitte.com/insights/us/en/industry/public-sector/mobile-health-care-app-features-for-patients.html>

Case Study – Partnering with a Local Provider to Resolve Scheduling Challenges

A local Kentucky practice with integrated Arcadian Telepsychiatry technology was running into challenges with patients arriving late to or missing their appointments. To overcome this challenge, Humana worked with the practice to create a two-pronged solution. First, we coordinated transportation for patients to help ensure they arrived on time for their telehealth appointments. Second, we built an “umbrella schedule,” which allows multiple clinics to schedule appointments on the same virtual provider’s calendar. This affords these patients greater flexibility in the days and times that they can schedule their telepsychiatry or telebehavioral health appointments in their PCPs’ offices.

d.

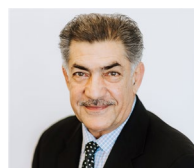
Describe the Vendor’s provider contracting strategies, including processes for determining if a provider meets all contracting requirements (at the time of enrollment and on an ongoing basis), as well as processes for corrective action and termination.

Include copies of the Vendor’s proposed contract templates for individual practitioners and for facilities as attachments.

Humana’s approach to provider contracting is developing easily accessible networks of high quality providers. We are able to leverage our existing experience across Medicaid, Commercial, and Medicare and our deep local understanding to build and maintain a robust network in Kentucky.

We have simplified our contracting process by maintaining provider recruitment mailboxes where providers can electronically submit an application to become a Humana provider. **Because our Provider Relations representatives and QIAs are based locally and often “in the field” at provider offices, we receive insight about new providers, enabling us to target them for recruitment.** Our efforts to recruit providers and maintain adequate networks are essential in order for Enrollees to receive the highest quality care when needed. Our Provider Network teams both in Kentucky and across the nation negotiate agreements that are fair and mutually beneficial to both parties, thereby maintaining successful ongoing professional provider relationships.

Humana dedicates more than 1,000 full-time employees nationwide to provider network management, recruitment, operations, education, and value-based contracting. Our Medicaid Provider Network team in Kentucky, led by Majid Ghavami, our Provider Network Director, has significant experience. Our current Provider Network associates each have an individual average of 26 years of provider contracting experience in the Commonwealth and more than 107 years of combined experience in the healthcare industry. Humana has developed contracting strategy guidelines to ensure all contract agreements are complete, consistent, manageable, legally compliant as well as contractually administrable. These standards ensure contract agreements are transparent and clear between the contracting parties.



ASSOCIATE SPOTLIGHT: Majid Ghavami

Majid is proud to serve as the Provider Network Director for Humana’s Kentucky Medicaid plan. He holds a Bachelor’s degree in accounting from Bellarmine University. Majid has called Kentucky home for more than 40 years and has more than 31 years of experience in provider services and network operations – 20 of which have been with Humana in various roles. Majid’s team is responsible for overseeing all provider services and network development activities and coordinating with credentialing verification organizations.

Humana's Provider Manual is an extension of our contract agreements. The Provider Manual includes important information concerning Humana's policies and procedures, claims submission, and adjudication requirements and guidelines used to administer our Medicaid plan. Providers can easily access the Provider Manual through Humana.com and Availity.com. Providers are contractually required to comply with all provisions contained in the Provider Manual. However, in the event of a conflict between the obligations and terms and conditions of the participation agreement and the Provider Manual exists, the obligations, terms and conditions of the participation agreement take precedence.

Adherence to Contractual Requirements

We ensure that any provider who contracts with us to serve Kentucky Medicaid Enrollees complies with all statutory program requirements. Providers are required to be enrolled with DMS as a Medicaid provider. Per 907 KAR 1:672(2)(c)(1), an individual or entity that wishes to participate in the Medicaid program shall be enrolled as a participating provider prior to being eligible to receive reimbursement, in accordance with federal and State laws. Humana collects providers' DMS-issued identifier at initial contracting.

Providers are an essential part of Humana's mission to assist Enrollees in achieving lifelong well-being. Through our credentialing and re-credentialing processes we ensure contracted providers are qualified to deliver the highest quality of care to our Enrollees. We have deep experience credentialing providers in Kentucky – Humana's home state. Since 2013, we have credentialed more than 11,000 providers and re-credentialed more than 8,000 providers across all lines of business in Kentucky. This includes credentialing more than 7,400 providers and re-credentialing more than 5,500 providers for our Kentucky Medicaid plan. Humana's proprietary workflow management tool, Accelerated Provider Exchange (APEX), quickens and automates the credentialing, provider load, and provider demographic update processes, allowing us to achieve best-in-class turnaround times. To ensure providers are ready to provide services to Humana Enrollees, we require all providers to complete a thorough credentialing process and ongoing re-credentialing process. Humana's qualification and verification processes are ongoing, and providers are re-credentialed at a minimum of every three years.

Two-way communication is essential to successful implementation of a new Contract. During our recent implementation of a new Medicaid Contract in Florida, we held town halls in each Service Region to solicit provider feedback and disseminate information to providers. We will conduct similar town halls in Kentucky by hosting events in each region during implementation and then periodically whenever there are significant programmatic changes.

Once a provider contract is fully executed, our local Provider Relations team initiates new provider orientation. We developed the orientation as a consistent process to ensure that newly contracted Humana network providers receive appropriate training on Humana's procedures. Within 30 days of the date of the executed finalized Medicaid Contract, the Provider Relations representative takes the following actions:

- Sends the New Provider Orientation packet to provider
- Confirms provider's understanding of the Provider Manual and Principles of Business Ethics
- Schedules and completes the in-person Provider Orientation
- Completes the New Provider Orientation Checklist – we record provider and office staff attendance at the orientation on the Checklist

After initial contracting and new provider orientation, ensuring adherence to contractual obligations, which is supported by our comprehensive Provider Education Strategy, remains a primary function of the provider's assigned Provider Relations representative. Our Provider Relations representatives use in-person meetings, emails, and phone calls to communicate plan updates and revise contractual requirements, policy changes, and other pertinent information to our network providers. Humana securely stores electronic information related to provider interactions. Using this information, we can track distinct provider interactions across all platforms.

Humana has designed our Provider Education Strategy to address providers' varying knowledge bases and practice needs in a flexible and engaging manner to ensure that information is both accessible and convenient. For example, we communicate information to providers using a variety of interactive and on-demand methods including the Provider Advisory Committee, webinars, town halls, provider website, provider portal, Provider Services Call Center, Provider Manual, and newsletters. We continuously enhance our provider education program, adjusting to changing programmatic requirements and provider feedback.

Processes for Corrective Action and Termination

Humana is committed to successful, longstanding partnerships with providers. We have vast experience in working constructively through contractual or operational issues with providers as they arise. Humana's scale across all of our lines of business gives our organization more balanced leverage in our relationships with providers, thereby, lessening the risk of major contract terminations.

Corrective Action: When needed, Humana has processes to put corrective action plans in place if providers have challenges ensuring equal access to care for all Humana Enrollees or meeting our network monitoring requirements (e.g., appointment wait times). Providers on a corrective action plan are placed on a monitoring schedule and persistently re-evaluated. Failure to resolve the noncompliance at the end of the corrective action plan period may result in termination. For example, if our Provider Services staff identify noncompliance with ADA requirements during an office visit or through an Enrollee grievance, Humana takes appropriate action, which may include but is not limited to freezing the PCP's panel to new Enrollees and implementing a corrective action plan.

Major/Significant Termination: A major or significant termination is defined as a change that involves 1) any hospital, 2) impacts a large number of providers (25 or more), or 3) any other network change that may have a negative impact on the network, causing the network to be at risk for not meeting State or federal access requirements. Significant provider contract re-negotiations can impact future network capacity planning. Humana's Provider Services staff maintains a strategic stratification of our major health system negotiations so that no more than one health system in a market is under negotiation at any given time. We discuss our policies and procedures for addressing a sudden and/or major provider termination in sub-question I.C.18.h of this response.

Provider-Initiated Terminations and Non-Renewals: Providers must provide Humana with notice in accordance with the terms outlined in the Participation Agreement regarding any termination or non-renewal in order to allow Humana to comply with the Enrollee notification timeframes required by applicable State and/or federal law, accreditation standards, Commonwealth Medicaid and/or dual eligible Medicare-Medicaid Draft Medicaid Contract requirements. The notification to Humana must be in writing and comply with the contractual requirements for notice to initiate the Participation Agreement termination. Upon notification of an impending network termination, Humana will send out written notices after Department approval to all affected Enrollees advising them on the situation and providing information regarding how to select a new PCP, if applicable, and Humana resources available to them during this period. These notices will be sent no more than 15 calendar days prior to the effective date of termination via electronic means and via certified mail within one business day of the decision being rendered. If an Enrollee does not proactively choose a new PCP, we will automatically assign them to a PCP. However, an Enrollee reserves the right to change their PCP with cause at any time, and enrollment with the new PCP is effective immediately. More details about how Humana supports the PCP selection or auto-assignment process and maintain continuity of care during a provider termination are discussed in sub-part I.C.18.h of this response.

Please refer to the following attachments for Humana's proposed contract templates:

- Attachment I.C.18.d-1 HUM KY Medicaid Physician Template
- Attachment I.C.18.d-2 HUM KY Medicaid Ancillary Template
- Attachment I.C.18.d-3 HUM Physician All Products Template
- Attachment I.C.18.d-4 HUM Ancillary All Products Template

- Attachment I.C.18.d-5 HUM Hospital All Products Template
- Attachment I.C.18.d-6 HUM IPA All Products Template
- Attachment I.C.18.d-7 HUM PHO All Products Template
- Attachment I.C.18.d-8 KY HUM Phys Medicaid Amendment

e.

Demonstrate progress toward developing network capabilities for statewide access by providing evidence of existing contracts or signed Letters of Intent with providers by provider type (for the Vendor and Subcontractor). Include the following information at a minimum:

e.i.

A Microsoft Excel workbook by provider type listing every provider that has signed a contract or Letter of Intent, including the provider's name, specialty(ies), address and county(ies), Medicaid Region(s) served, whether the provider is accepting new patients, accessibility status for individuals with disabilities, language spoken, and the provider's Medicaid Identification Number(s).

Pursuant to Addendum 1 of the solicitation, please refer to **Attachment I.C.18.e-1 Humana Kentucky Medicaid Provider Network** ("KY PROVIDER NETWORK" tab) on the flash drive for the completed Excel workbook.

e.ii.

A summary Microsoft Excel worksheet with total provider counts by provider type by Medicaid region and county.

Pursuant to Addendum 1 of the solicitation, please refer to **Attachment I.C.18.e-1 Humana Kentucky Medicaid Provider Network** ("KY SUMMARY COUNT" tab) on the flash drive for the summary Excel tab.

e.iii.

A statewide Geographic Access report of all providers with LOIs and/or existing contract color coded by provider type by Service Region.

Please refer to **Attachment I.C.18.e-2** for the statewide Geographic Access report.

f.

Describe proposed Enrollee to provider ratios by provider type, as well as the Vendor's methodology for considering a provider's FTE when calculating network adequacy standards.

Humana's proposed Enrollee-to-provider ratios provide a baseline for how many physicians in various specialties a service area may need. As part of our ongoing provider network monitoring, we have established proposed Enrollee-to-provider ratios for specific high-volume specialists. Our ratios were developed by taking into account standards defined by the Department, our internal experience, including review of monthly network ratio reports, ratios defined by states with similar demographics, and national standards recommended by CMS and associations, such as the AMA. Humana is and will continue to comply with the Department's established Enrollee-to-Provider ratio of 1,500:1. To propose provider ratios for other specialty types, Humana analyzed national provider ratio requirements in other Medicaid programs to determine appropriate benchmarks.

Humana far exceeds the Department's required Enrollee-to-PCP ratio with a current ratio of approximately 33 Enrollees to one PCP.

Table I.C.18-4 Proposed Enrollee-to-Provider Ratios

Provider Type	Proposed Ratio	Humana Kentucky Medicaid Actual Ratio**
PCP	1,500:1*	33:1
Allergy	50,000:1	2,337:1
Cardiology	5,000:1	268:1
Cardiovascular Surgery	10,000:1	1,043:1
Dermatology	20,000:1	2,164:1
Gastroenterology	15,000:1	732:1
General Surgery	5,000:1	381:1
Infectious Diseases	10,000:1	2,042:1
Internist	2,000:1	81:1
Midwife	10,000:1	2,302:1
Nephrology	25,000:1	208:1
Neurology	15,000:1	469:1
OB/GYN	2,000:1	292:1
Oncology	10,000:1	780:1
Optometry	10,000:1	265:1
Ophthalmology	15,000:1	628:1
Orthopedic Surgery	10,000:1	432:1
Otolaryngology	10,000:1	1,198:1
Pharmacy	5,000:1	141:1
Therapist (Occupational)	10,000:1	665:1
Therapist (Speech)	10,000:1	858:1
Therapist (Physical)	10,000:1	263:1
Urology	20,000:1	960:1
Psychiatry	5,000:1	382:1
Behavioral Health Service Organizations	15,000:1	1,198:1

*Indicates Department-defined ratio requirement.

**Actual ratio based on 145,000 Enrollees.

INCORPORATING PROVIDER FTE INTO NETWORK ADEQUACY

Our Provider Network team is meticulous when ensuring our network adequacy standards meet the needs of our Enrollees. PCPs must work a minimum of 24 hours per week to be included in our network adequacy calculations. We use physician extenders to meet PCP network ratios, as well as time/distance standards, including nurse practitioners and physician assistants linked to a physician group providing primary care services.


















g.

Describe the Vendor's proposed methods for ongoing monitoring and assessment to ensure compliance with network adequacy and access to care standards, including tools used, the frequency of reviews, and how the Vendor will use findings to address deficiencies in the Provider Network. The response should also address how the Vendor monitors appointment availability and wait times.

Provide samples of tools and/or reports.

Humana continuously measures and evaluates timely Enrollee access to providers with a robust set of monitoring tools and comprehensive oversight mechanisms that allow for the quick identification and subsequent development of targeted resolutions of gaps. We continuously assess our network and analyze capacity in each Service Region across all available provider types to exceed compliance with network adequacy standards and after-hours availability. Our process measures performance against contractual requirements, allowing us to identify and resolve network gaps, address barriers to care, and enhance preventive care.

Figure I.C.18-1 Network Gap Measurement Tools

Time/Distance Standards	Appointment Availability & After-Hours Care
 Geographic Mapping	 Secret Shopper Calls
 Provider-to-Enrollee Ratios	 After-Hours Accessibility Audit
 Out-of-Network Referrals Ratios	 Incentivizing Providers to Offer After-Hours Clinic Availability
Open/Closed Panels	Cultural Competency
 Review of Open and Closed Panels	 Cultural Needs Assessment
 Inquiries Related to Provider Access or Availability	 Linguistic Needs Assessment
Additional Comprehensive Network Access	
 Enrollee Surveys	 Provider 360 Committee Feedback
 Provider Satisfaction Surveys	 Associate, Enrollee, Provider, and Advisory Committee Input
 Customer Care Associates	 Oversight of Network Accessibility
 Subcontractor Review	

Time/Distance Standards Measurement Tools

Geographic Mapping: Humana uses Quest Analytics, a geocoding technology tool, to measure Enrollee-to-provider adequacy access at the regional and zip code levels. Our Provider Network team runs and reviews reports quarterly or more frequently as deemed necessary. We analyze access for the Department's required specialties by Enrollee age and gender and culturally competent care as indicated for the provider type. For example, we map pediatricians to Enrollees under the age of 21 or OB/GYNs to female Enrollees. Quest's proprietary algorithm produces reports that compare an Enrollee's home address to a provider's office location to help Humana better understand the Enrollee travel experience and adapt our network accordingly. This

allows us to contract with additional providers and partner with physicians through our VBP programs to encourage practicing in underserved areas and adding hours for appointment availability. The report summarizes individual calculations to identify areas where Enrollees currently have access, as well as areas where additional network development is needed. Quest also generates maps that highlight Enrollee access and network deficiencies for review by our Provider Network and leadership teams.

Enrollee-to-Provider Ratios: Humana assesses Enrollee-to-provider ratios across all of our lines of business at least quarterly. This provider capacity assessment is done by considering standards defined by the Department, our internal experience, and national standards recommended by associations, such as the AMA. We examine ratios for each specialty by region using current enrollment data. When our Provider Network team reviews the monthly ratio report and identifies that any tracked provider type has reached at least 85% of their established capacity, we proactively begin recruiting additional providers of that particular provider type in the identified geographic area. This ongoing tracking of the availability of network providers over time helps ensure that Enrollees have access to care even as membership grows.

OON Referrals: We examine OON referrals quarterly to identify potential areas where we have an opportunity to expand specialty provider capacity. Our Contracting team and Provider Relations team will conduct outreach to the provider to offer a contract for network participation, leveraging relationships and our deep experience across the Commonwealth.

Appointment Availability and After-Hours Care Measurement Tools

Secret Shopper Calls: We conduct systematic network improvement efforts related to appointment availability. Throughout the Draft Medicaid Contract period, Humana will implement secret shopper telephone surveys to all network physicians who served 10 or more Enrollees during the prior six months. Any provider with an identified access concern will first receive education on the appointment availability requirements from their dedicated Provider Relations representative. Subsequently, we will follow up with the provider to ensure that the issue with appointment availability has been resolved. We will also add more frequent secret shopper calls from that point forward. The secret shopper survey monitors accessibility of appointments per Humana's and the Department's regulatory requirements and will validate after-hours access to a healthcare professional.

After-Hours Accessibility Audit: Humana calls provider offices quarterly (at a minimum) to ensure Enrollees have enhanced access to care during after-hours. Provider Services leadership reviews after-hours availability results and assigns them to the appropriate Provider Relations Representative for immediate outreach and education to the provider, if necessary.

Open/Closed Panels Measurement Tools

Review of Open and Closed Panels: On a quarterly basis, we will review the panel status of our PCPs by county and region. We use these data points to identify access barriers and implement additional targeted recruitment efforts. Upon identification of a closed panel, we will review network PCPs in the same geographic area to ensure there are enough PCPs with open panels to provide access.

Inquiries Related to Provider Access or Availability: Our Provider Resolution team uses Humana's Customer Relationship Management (CRM) tool and inventory management system, mhk, to identify, track, and trend Enrollee inquiries related to network access issues and non-compliant providers. Our state-of-the-art analytics platform, Clarabridge, conducts real-time analysis of provider grievances to identify red flag issues. The Provider Resolution team notifies the Provider Network team of urgent issues immediately and non-urgent issues on a weekly and monthly basis. The Provider Resolution team also reports monthly to the market-based operational and quality governance forums to assist with root cause analysis and process improvement opportunities.

Cultural Competency Measurement Tools

Cultural and Linguistic Needs: Humana strives to implement a culturally humble and diverse provider network. We conduct an annual comprehensive analysis (our access and adequacy assessment) of the cultural and linguistic needs of our Enrollees and their geographic concentration to ensure appropriate access to culturally

competent care. To identify and address health disparities, we will stratify our HEDIS results by age, race, ethnicity, gender, and zip code. We will share these insights with our network providers to inform their approach to service delivery for their patient panel. Additionally, we monitor Enrollee inquiries on an ongoing basis to ensure we can respond in a timely manner to any provider issues related to cultural and linguistic needs. All of our provider contracts contain language requiring providers to treat Enrollees without prejudice. Our Population Health Management Director, Adrienne McFadden, MD, JD, will monitor our adherence to National CLAS Standards.

Additional Comprehensive Network Access Measurement Tools

Enrollee Surveys: Humana annually conducts and reviews the results of the CAHPS survey to identify trends in barriers to care. We measure access to care results year-over-year in comparison to our established benchmark goals and report the analysis of the results to our Kentucky Medicaid QIC to ensure we meet our benchmark goals. We conduct CAHPS pulse surveys in addition to the annual surveys to gain insights into Enrollee experiences. These surveys are conducted mid-cycle between annual CAHPS surveys.

Provider Satisfaction Surveys: We annually conduct provider satisfaction surveys and review the results to identify any issues related to network adequacy or to develop targeted training and education curricula.

Member Services Representatives (MSR): We will train our MSRs in our Kentucky-based Member Services Call Center to assist Enrollees with accessing care. For example, these MSRs will arrange transportation, locate a provider, or assist Enrollees with scheduling an appointment. MSRs record Enrollees' inability to find specialists to meet their needs in CRM. This team submits weekly reports related to network adequacy to the Provider Network team for identification and remediation of any network gaps.

Subcontractor Review: Humana requires our Subcontractors to provide network data on a monthly basis. We analyze the data against our adequacy standards to identify any issues. We are also closely integrated with our Subcontractors through regularly scheduled JOC meetings, where we review a range of functions including claims, clinical management, compliance, and Enrollee Services, allowing us to assess network adequacy through a variety of avenues.

Provider 360 Committee Feedback: Our Provider 360 Committee is a cross-functional team chaired by Humana's Provider Network Director, Majid Ghavami. The Committee meets monthly to review provider trends related to claims, use of Availity (Humana's secure provider portal), quality metrics, grievances, and other provider inquiries. The committee includes representatives from our Claims, Grievance, and Appeals; Credentialing; Provider Services; and utilization management departments.

Associates, Enrollee, Provider, and Advisory Input: On an ongoing basis, Humana also examines anecdotal information from various internal and external sources such as Enrollee Services, UM, PAC, and the Quality and Member Access Committee as it pertains to network adequacy. We review this information to identify and pursue contracts with providers who are needed to serve Enrollees, even after the regulatory adequacy requirements are met. This includes information contributed by individuals and committees, such as PAC, as well as recommendations from providers to Humana to contract with specific providers and provider types.

We have a multi-tiered review process to monitor the reports from our network adequacy tools. This review process applies to all provider types as well as to our subcontracted entities. We conduct the process on an ongoing basis to ensure that we are proactively deploying network recruitment efforts and quickly responding to network gaps as they arise. Comprehensive provider network monitoring helps us ensure our Enrollees have access to the providers and services they need. Below, we describe the oversight and monitoring of the data generated from the sources listed above.

- Provider Network team: Our Kentucky Provider Network team meets weekly to review reports from our network adequacy and availability tools and determine opportunities to improve the network. This team is responsible for deploying recruitment and retention efforts and has direct interaction with providers.

- **Quality Improvement Committee:** The QIC is responsible for objectively and systematically monitoring and evaluating the quality and appropriateness of care and services and for promoting improved patient outcomes. Humana's Kentucky Medicaid Medical Director, Lisa Galloway, MD, and Quality Improvement Director, Audra Summers, will co-chair the QIC, with our BH Director, Liz Stearman, CSW, MSSW, serving as a voting member. Additional committee members include our network medical and BH providers and Humana associates representing various Humana departments.

Please refer to **Attachment I.C.18.g-1 Sample Tools and Reports** for examples of customizable tools that we use to monitor network adequacy and inform our network management strategy.

h.

Describe how the Vendor would respond to the network termination or loss of a large provider group or health system. Include information about the following at a minimum:

While Humana has never had a major network termination in Kentucky, we are prepared to respond swiftly to ensure continuity of care for all affected Enrollees in the event this occurs. Humana has robust processes to help notify the Department and Enrollees and a library of resources (reviewed annually) to assist in the transition of care. **Attachment I.C.18.h-1** provides a screenshot of our resource library that is accessible to assist Enrollees affected by a major termination. Also, see **Attachment I.C.18.h-2 Network Termination Policy and Procedure** for our network termination process documentation, which will be updated to include any Draft Medicaid Contract requirements.

Humana's provider contracts contain standard Term and Termination provisions describing types of terminations (e.g., immediate, without cause, with cause, etc.), as well as the requirements that govern actions at initiation and throughout a termination. A major or significant termination is defined as a change that involves (1) any hospital, (2) impacts a large number of providers (25 or more), or (3) any other network change that may have a negative impact on the network, causing the network to be at risk for not meeting State or federal access requirements. If our network experiences the loss of a large provider group or health system, Humana operates in accordance with the following actions described in detail in sub-questions I.C.18.h.i-iii:

- Immediately notify the Department
- Identify affected Enrollees and communicate the termination and next steps
- Develop and execute Continuity of Care Plan for affected Enrollees
- Conduct an assessment of network impact and implement strategies to address deficiencies

h.i.

Notification to the Department and Enrollees.

Although Humana will take all measures to avoid a network termination or loss of a large-scale provider group, in the event that such termination occurs, Humana will notify the Department within three days of any significant changes to the Provider Network in accordance with the Draft Medicaid Contract. Humana will also provide the Department with a Continuity of Care plan on transferring Enrollees to new providers and minimizing disruptions in care.

Upon recognition of a significant network termination, Humana will send out written notices to all affected Enrollees advising them of the situation and providing information regarding new provider assignment and Humana resources available to them during this period. These notices will be sent no more than 15 calendar days prior to the effective date of termination for PCPs and no more than 30 calendar days for all other providers. Our policies and procedures to reassigning Enrollees is described in sub-question I.C.18.h.ii of this response. See **Attachment I.C.18.h-3 Sample Network Term Notification Letter** for a sample notification letter that would be sent to an Enrollee; this letter will be updated to reflect any updated requirements under the Kentucky Draft Medicaid Contract.

In the event of a sudden and unexpected network termination (we learn of the termination less than 30 days prior to the effective date), we will notify affected Enrollees as soon as possible and will utilize our Kentucky-based Member Service Call Center to conduct immediate outreach. Our call center associates will inform Enrollees of the change and assist them in choosing a new PCP. Humana will also notify the Department of the change within three days.

h.ii. Transition activities and methods to ensure continuity of care.

Humana works hard to prevent provider terminations; however, in the event of a major and/or sudden termination, we enact the following strategies to preserve continuity of care:



- Allow Enrollees receiving medically necessary care to continue with the terminating provider through completion of treatment or transition to another provider
- Engage Enrollees to assist them in selecting a new PCP and/or reassign them to a new PCP using our intelligent assignment algorithm
- Utilize our care management team to assist the Enrollees with whom they work to select and engage with their new PCP

PRESERVING ACCESS TO MEDICALLY NECESSARY AND PRENATAL CARE

In an effort to minimize disruption, when care being received at the time of termination is deemed medically necessary, Humana allows Enrollees in active treatment to continue care with a terminated treating provider through completion of a treatment or until the successful transition to another provider. Treatment, as described, can last up to 90 days after the termination of the provider's contract (or for as long as required by any applicable law and regulation). Humana will also allow pregnant Enrollees who have initiated a course of prenatal care, regardless of the trimester in which the case was initiated, to continue care with a terminated treating provider until completion of postpartum care.

PCP SELECTION AND AUTO-ASSIGNMENT

As discussed earlier in this response, if a PCP leaves Humana's network, we provide written notification alerting them of the PCP termination and directing Enrollees to our Member Services Call Center to select a new PCP. Similarly, in the event of a sudden termination, we conduct an outreach campaign to Enrollees through our Member Services Call Center. Enrollees can select a new PCP by speaking with Humana's Member Services Call Center, visiting our MyHumana Enrollee portal, or through their CM. However, if the Enrollee does not self-select, we use our automated PCP assignment process to assign a new PCP. Once an Enrollee selects or is assigned a new provider, we send the Enrollee an updated Enrollee ID card, which they can also print through our Enrollee portal.

Humana adheres to the procedures for auto-assignment delineated in Section 23 of Attachment F of the Draft Medicaid Contract. Our intelligent PCP auto-assignment algorithm accounts for a number of factors when making PCP determinations:

- Geographic Proximity: Distance between the new PCP from the Enrollee will meet driving/distance access standards. We utilize a 30 miles/30 minutes rule and consider transportation options.
- Previous PCP relationships: Historical claims utilization will be taken into account where possible
- PCP Panel size: PCP capacity to take on new Enrollees
- Gender: Gender of the provider should align with Enrollee preferences. We match Enrollees to the same gender provider (when feasible) if their preference is not specified.
- Cultural/language needs: Language fluency between Enrollee and provider whenever possible
- Provider Quality Performance: Prioritize assignment to high-performing providers; we utilize quality performance metrics and analytics through our Care Decision Insights platform

We also account for Enrollees' unique needs during reassignment described in **Table I.C.18-5**.

Table I.C.18-5 Considerations during Enrollee PCP Reassignment

Adolescent Need	The algorithm identifies a provider pool that is inclusive of pediatricians and prioritizes the assignment to Enrollees under 18 to these providers.
Special Needs Humana puts Enrollees with Special Health Care Needs into the following categories and assigns appropriate PCPs based on the following criteria:	Pregnancy: Enrollees who are identified as pregnant on the 834 file are assigned to a PCP who provides obstetrical care or are referred to an obstetrician.
	Severity Score: Supplemental Security Income (SSI) data that are attributed on the 834 will match providers who indicate they provide support for chronic or complex care, are a PCMH recognized, and/or have integrated BH services.
	To ensure an SSI Enrollee does not go without a PCP for more than 30 days, we auto-assign a PCP to the Enrollee and provide three follow-up outreach efforts that include a letter and call at 60 days and a call at 90 days. If the Enrollee arrives in the ED during the 90-day timeframe, a care management associate contacts the Enrollee to assist with their needs, reassess their severity score, and reviews PCP assignment.
	Language and Cultural Competency: This approach assigns a PCP based upon matching the Enrollee's home address zip code to the provider's practice address zip code and matching the Enrollee's expressed language preference to a provider with a similar "language spoken here" record.
We also use an enhanced "smart" algorithm (i.e., a Family/Sibling Algorithm) to support Enrollee needs	We are committed to keeping all Enrollees of a family with the same PCP if possible and appropriate. To accomplish this, our algorithm assigns Enrollees under the age of 18 and their family members who are Humana Enrollees to the same in-network PCP.

Lastly, to ensure continuity of care for Enrollees affected by the network termination, we will provide all newly assigned PCPs or specialists with all care plans, pharmacy claims, and medical records from the previous provider. We will also work with the terminated provider to obtain any additional information regarding the affected Enrollees.

LEVERAGING THE CARE MANAGEMENT TEAM TO SUPPORT CONTINUITY

Humana has designed our continuity of care processes to support seamless transitions of care for Enrollees with special health care needs. In the case of any provider termination, Humana CMs conduct outreach to their Enrollee in care management who is affected by the termination to help them locate a new provider who can meet their needs. Most often our Enrollees enrolled in care management have multiple complex conditions. While Humana's network is extremely robust, if following a provider termination we can no longer meet this Enrollee's needs through an in-network provider, we will help them arrange a single case agreement with an OON provider who can meet their needs. The CM will work with the Enrollee's new provider to ensure continuity of care and coordination of services, including sharing the Enrollee's care plan (with Enrollee permission) and advising on any authorizations.

h.iii.

Analyses the Vendor will conduct to assess impact to network adequacy and access, and how the Vendor will address identified deficiencies.

Humana utilizes a wide range of tools to monitor network adequacy on an ongoing basis as described above in sub-question I.C.18.g. Upon notification of a major and/or sudden provider termination, Humana will bring together a Major Provider Termination workgroup to assess impact, identify and roll out solutions to address any deficiencies. The workgroup will bring together leaders from diverse business segments across the

organization, including network development and contracting, provider relations, data analytics, and clinical leadership; our Kentucky Medicaid Provider Network Director, Majid Ghavami, will lead this workgroup. Under the guidance of the Major Provider Termination workgroup, Humana's Provider Network team will conduct a formal network termination impact analysis. This includes using Quest Analytics to analyze access with GeoAccess reports, reviewing open and closed panels, and evaluating Enrollee-to-provider ratios to avoid any Enrollee access issues. If additional views into network data are needed, our Provider Network team can create custom reports to allow for additional cross-examining of the network's coverage and needs. This analysis serves as the basis to initiate efforts to fill identified gaps caused. The Major Provider Termination workgroup will identify short- and/or long-term solutions for each unique instance where a major or sudden provider termination occurs using the following mechanisms:

- Leverage our extensive Medicare and Commercial lines of business in Kentucky (or a border states as appropriate) to identify providers who are not participating with us for Medicaid. Humana will perform outreach to those providers and offer a contract amendment to bring that provider into our Medicaid network.
- Identify all additional providers who meet that provider type serving in the Service Region but do not have existing relationships with Humana and conduct outreach to offer a contract for Kentucky Medicaid and/or other lines of business, as relevant
- Recruit providers who will bring a discrete component of the network into compliance with the accessibility standards into the network
- Document our efforts in extending reasonable offers to providers in an area identified with an accessibility gap but were unable to successfully contract and are still unable to secure network participation in this given area to the Department
- Seek needed providers through securing letters of agreement with non-participating providers and permit Enrollees to seek care from these providers on an OON basis in the absence of a contract
- Identify the reasons for provider termination and, as appropriate, incorporate that provider's feedback into our provider retention strategies

Finally, while longer-term solutions are developed to remediate any network deficiencies, Humana will offer transportation services, as needed and appropriate, to the nearest provider for our Enrollees to ensure they are able to access needed services.