

C. Technical Approach

20. Covered Services (Section 30 Covered Services)

Our approach to delivering Kentucky Medicaid Covered Services focuses on providing integrated, person-centered care that drives positive health outcomes. Our integrated service delivery model provides support across the full continuum of physical health, behavioral health (BH), pharmacy, and social services (both covered and non-covered), with an emphasis on preventive care, population health, reducing potentially preventable events, and addressing Social Determinants of Health (SDOH). To support this approach, we partner with Community-Based Organizations (CBO), providers, and the Commonwealth's agencies to promote collaboration, coordination, and innovation.

- a.** Provide a detailed description of how the Vendor's operational structure and practices will support integrated delivery of services (i.e., staff, contractors, systems, calls centers, etc.). In addition, the Vendor's response should address:

Humana brings a fully integrated model to Kentucky. This operational model is designed to holistically address our Enrollees' physical health, BH, and SDOH needs and engage Enrollees to promote self-care and wellness activities. In addition, we are committed to advancing integration at the provider level through the delivery of tailored support, education, and value-based payment (VBP) models that enhance our providers' ability to improve health outcomes. Humana has invested in technology platforms that support integrated delivery of services and provide a centralized, 360-degree view of our Enrollees, inclusive of physical health, BH, pharmacy, and SDOH information, to all associates. As a Kentucky-based company, Humana has served the Commonwealth for almost 60 years. We will continue to work with the Commonwealth, its agencies, and its contractors to advance integration and deliver high-quality services to our Enrollees.

ASSOCIATES

Our Comprehensive Care Support (CCS) team supports integration in our clinical model by bringing together Humana associates trained in multiple disciplines (including BH, physical health, pharmacy, and SDOH) under a **single model of care**. This team structure allows our Enrollees to access a single point of contact for their care needs, even if they have co-occurring physical health, BH, and/or SDOH needs. Information and collaboration across the care team is driven by an integrated team model and facilitated by our fully integrated clinical platform, Clinical Guidance eXchange (CGX), which provides our team a whole-person view of medical, behavioral, pharmacological, and social needs/services for all our Enrollees. This shared and fully comprehensive clinical platform tool allows our CCS team to seamlessly support the array of needs an Enrollee may face.

Our provider supports, including our Practice Innovation Advisors, are trained and equipped to support integration at the provider level and provide quality analytics to support improved quality of care. Our Kentucky-based call center associates can help Enrollees find a physical health or BH provider, arrange new ID cards, complete Health Risk Assessments (HRA), and connect Enrollees with specialized associates [e.g., our SDOH coordinators and Care Managers (CM)] to support Enrollees' physical health, BH, and SDOH needs. Our Pharmacy benefit manager (PBM), Humana Pharmacy Solutions, Inc. (HPS), is a Humana subsidiary; therefore, pharmacy data are integrated into our clinical platform, CGX, to support the delivery of integrated care by our CCS team.

CONTRACTORS

Humana uses carefully selected delegated subcontractors with a depth of Medicaid experience to cover dental services, vision services, and 24 hours a day, seven days a week Medical advice line and BH Crisis Line services.

For select services, we use administrative subcontractors for functions including (but not limited to) utilization management (UM), claims processing, network management, and interpretation and translation services. We select subcontractors with strong performance metrics and positive reputations and aim to integrate delegated services into our core operations to the extent possible. For example, we require our 24 hours a day, seven days a week Medical advice line and BH Crisis Line partners to provide daily call logs for Humana Enrollees. We use this information to ensure next business day follow up with the Enrollee to ensure they received recommended services and to assist with linkage to continuing care. As additional support for our subcontractors, we provide Enrollee data as necessary to conduct their delegated responsibilities. A full list of our known subcontractors can be found in Section I.C.1 Subcontracts of the Request for Proposal.

We have partnered with Avēsis for delegated dental and vision services. We share monthly eligibility and daily change files and receive weekly authorization data feeds, weekly encounter files, weekly provider data feeds, daily claims data feeds, and daily customer service data feeds in return.

We use a company-wide coordinated approach for delegation oversight that includes Kentucky Market Operations, Delegation Compliance, First Tier Downstream Related Entity Compliance, and Regulatory Compliance. We report the results of monitoring and oversight of our subcontractors to the Subcontractor Oversight Committee (SOC). The aim of our delegation oversight procedures is to ensure the quality of subcontracted functions and compliance with contractual requirements.

OPERATIONAL SYSTEMS

Humana has designed our systems to house all Enrollee information into centralized platforms: our clinical technology platform, CareHub; our integrated clinical platform, CGX; our provider portal, Availity; and our population health management (PHM) platform, Population Insights Compass (Compass). These platforms that include physical health, BH, pharmacy claims, and SDOH information. As a fully integrated approach, our enterprise solution is designed to drive better Enrollee outcomes, enhance sharing of clinical data, and drive more consistent decision-making. **Figure I.C.20-1** illustrates how our systems integrate data to support our Enrollees, providers, and associates, beginning from the time that an Enrollee joins Humana.

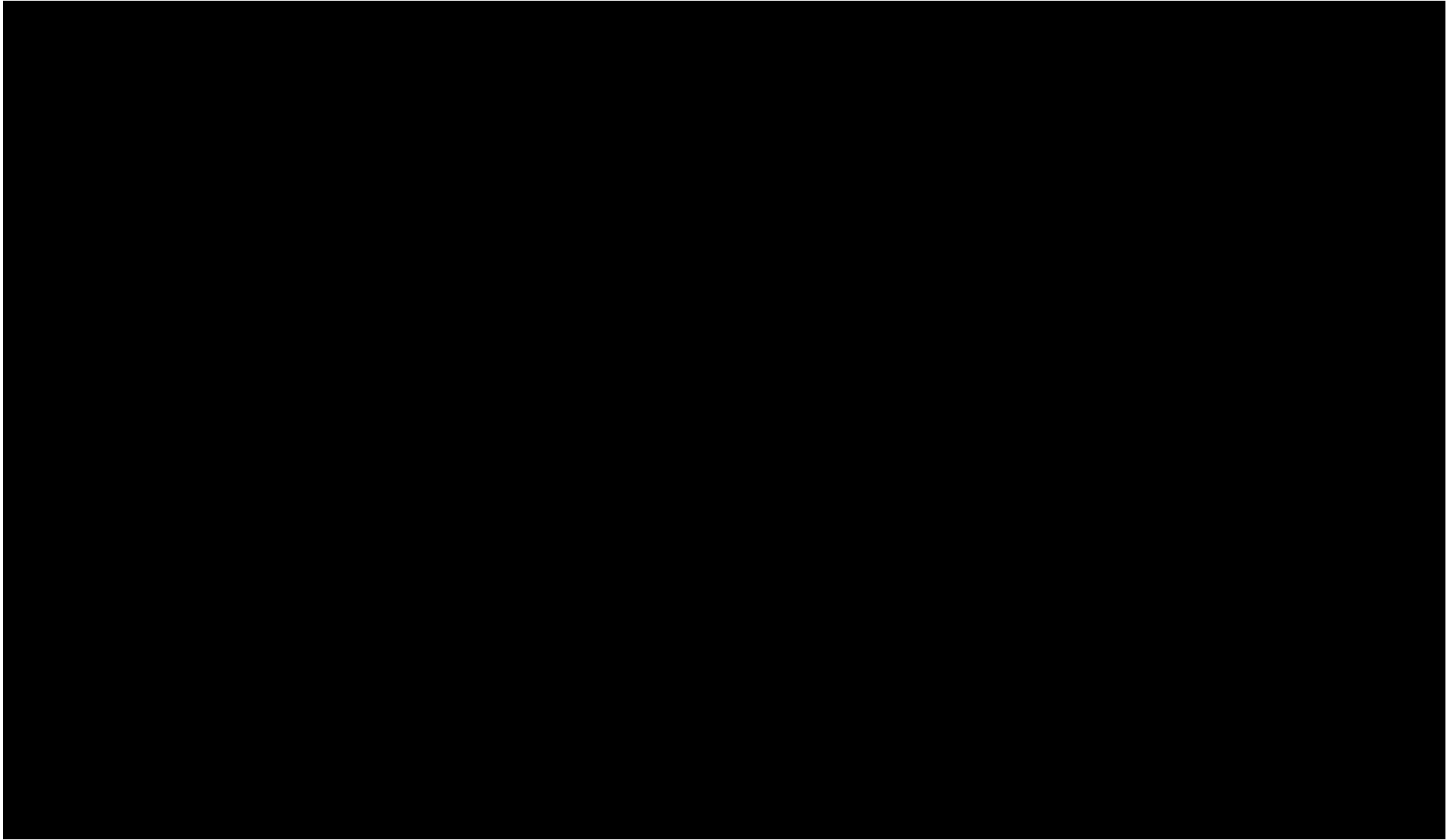


Our CareHub platform integrates Enrollee data from a variety of sources (e.g., claims, the HRA, biometrics, personal health profile, and lab tests) through CGX, which in turn, supports our Clinical Insights Engine and clinical analytics. As a fully integrated platform, CareHub supplies enhanced capabilities to identify Enrollees eligible for our clinical programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention.

Our clinical platform, CGX, provides a 360-degree view of the Enrollee's clinical profile, including care plans, authorizations, recent claims, and communication history. CGX compiles information on BH and physical health services, as well as information captured on SDOH needs through Enrollee assessments, care planning, and individual Enrollee requests for SDOH support directed to our SDOH coordinators. CGX provides a holistic, comprehensive view of our Enrollees to our Enrollee-facing associates, including our Humana CMs, Community Health Workers (CHW), SDOH coordinators, and Housing specialists. We also use CGX to store information about Enrollees received from third parties, including provider-employed CMs, State agencies, and other health plans, enhancing our own data about Covered Services with information about any community resources or non-Covered Services the Enrollee is receiving.

Our integrated systems extend to our provider-facing tools. Humana's network providers have access to a 360-degree view of each Enrollee's clinical profile through our provider portal, Availity, which provides a view of the Enrollee's eligibility benefits, care alerts, care plans (with the Enrollee's permission), assessments, and claims, inclusive of the Enrollee's physical health, BH, and SDOH needs and services. Primary Care Providers (PCP) can also access information about Enrollee- and practice-specific information about care gaps, medication adherence, care history, and services (including pharmacy) using Compass, our provider PHM platform.

Figure I.C.20-1: Humana's Clinical Technology Platform and Integrated Systems



CALL CENTERS

Enrollees can call our Medical advice line, BH Crisis Line, or Member Services Call Center directly using the number printed on their Enrollee ID card. Alternatively, Enrollees can use our Interactive Voice Response (IVR) system to connect to the line of their choice or can be warm transferred between lines. Our **Kentucky-based Member Services Call Center** handles queries about physical health, BH, and SDOH services and use Humana's Community Resource Directory (CRD) and the Unite Us digital care coordination and referral-tracking platform to support connections with community resources. Our Kentucky Enrollee Services associates are managed by our Enrollee Services Manager, Sarah Porter.

Our Member Services Representatives (MSR) can view historical claims and gaps in care (including prescription refills) through Customer Relationship Management (CRM), inclusive of the Enrollee's physical health, BH, and pharmacy benefits. Through CRM, MSRs can also task our Provider Services staff, our care management associates, our grievances and appeals department, and other Humana associates to conduct specific actions in follow up to the Enrollee's call. In addition, MSRs have access to a read-only view of CGX to view information on the Enrollee's providers, care plans, service histories, CM contact information, and communication records.

Our Provider Services Call Center handles provider queries about both physical health and BH and can link to our Humana Clinical Pharmacy Review (HCPR) call center or pharmacy technical help desk for pharmacy-related inquiries. We use CRM to support call management and access relevant Enrollee and provider information. Our Kentucky Provider Services Call Center is managed by Michelle Weikel.

a.i.

Innovative approaches to ensure Enrollees experience whole-person care that integrates their medical and behavioral health benefits and addresses social determinants of health.

Recognizing the benefit and necessity of integration in providing meaningful, whole-person care to our Enrollees, our providers, and the entire health system, Humana has invested in a fully integrated care model with associates experienced in managing physical health, BH, and SDOH needs. We are also experienced in implementing innovative provider contracting models that will advance integrated care in our Kentucky Medicaid Managed Care plan.

COMPREHENSIVE CARE SUPPORT TEAM

Our fully integrated CCS team is a key component of our Kentucky Medicaid PHM program. The CCS team provides a forum for our associates with expertise in the physical health, BH, and SDOH needs of Medicaid Enrollees to exchange information and ideas and support Humana Enrollees with co-occurring, complex needs. This team structure allows our Enrollees to access a single point of contact for their care needs, even if they have co-occurring physical health, BH, or SDOH needs. The CCS team includes an SDOH coordinator whose role is to help Enrollees link with resources that can address their SDOH needs. Enrollees can also receive individualized and face-to-face support from our CHWs. We make a concerted effort to hire CHWs who represent the communities we serve and share lived experience with our Enrollees.

PROMOTING INTEGRATION AMONG PROVIDERS

Humana works proactively with our provider network to develop capabilities and partnerships to enable delivery of integrated, whole-person care. We recognize that not all providers have the capabilities (or the desire) to adopt advanced integration models such as co-location. Therefore, we tailor our assistance to the individual provider's existing circumstances and identify steps to take to move along the Substance Abuse and Mental Health Services Administration's (SAMHSA) levels of integrated healthcare.

Our approach to promoting integration includes:

- **Humana associates dedicated to advancing integration**: Humana's provider support team (led by our Provider Services Manager, Michelle Weikel) is committed to advancing BH and physical health integration

among our network providers, including PCPs, pediatricians, OB/GYNs, and other specialists. For example, Humana's provider support team will collaborate with our network BH provider, InTrust, and medical providers interested in integration to explore opportunities for partnership, including developing data sharing or collaborative care agreements, negotiating co-location opportunities, or establishing pathways for telebehavioral health. InTrust brings extensive experience to BH and physical health integration, including experience with both co-location models and telebehavioral health.

- **Telebehavioral health:** Humana views telebehavioral health as an important avenue to improving access and advancing integration of BH services across the Commonwealth of Kentucky. In addition to our direct-to-consumer and self-management solutions (MDLIVE and myStrength, respectively), we will leverage solutions that improve the ability of our network PCPs and OB/GYNs to deliver BH services within their practices to support whole-person care:
 - **PCP-led telebehavioral health:** Humana has partnered with **Arcadian Telepsychiatry Services** to provide Humana Enrollees with access to a broad network of licensed and credentialed psychiatrists, psychologists and other behavioral health 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 service delivery model is optimized to deliver BH care, offering unprecedented access to BH services, particularly in areas of the state 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 providers' 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.
 - **Psychiatric consultation service:** Humana will offer a psychiatric consultation service for PCPs and OB/GYNs delivering 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 capacity, including systematic and evidence-based screenings, and treatment for mild or moderate BH conditions (including medication management, as appropriate), without further referral.
- **Monthly Healthcare Effectiveness Data and Information Set (HEDIS), medication adherence, utilization, and other reports and alerts provided via Availity and Compass:** These reports and alerts include both BH and physical health services, helping providers close care gaps and encouraging communication between the various providers engaged in the Enrollee's care. Our VBP program provides financial incentives for closing those gaps through direct service delivery or referral, as described below.
- **Provider incentives:** Humana has more than 52,000 PCPs in value-based arrangements across 43 states. In Kentucky, 81% of our Medicare Advantage Enrollees are attributed to PCPs in value-based arrangements. From this extensive experience implementing integrated provider arrangements and VBP across multiple lines of business, we recognize the ability of financial incentives to improve the delivery of integrated care and address SDOH. To this end, we will offer our Kentucky Medicaid providers seven unique financial arrangements related to integrated care:
 - **Rewards only arrangements:** We will reward our PCPs for performance on measures tied to depression screening and follow-up after ED visits and hospitalizations.
 - **BH Medical Home Incentive:** Through our network management initiatives, Humana will engage with selected BH practices to determine their interest and evaluate their capabilities to incorporate the offering of primary care services in their offices or clinics (e.g., hire a primary care nurse practitioner). To identify potential BH practices for this program, Humana will review our network access and adequacy reports to first determine if there are BH providers in primary care shortage areas that may be eligible for the program. Following agreement between Humana and the BH practice, Humana will remit the BH Medical Home Incentive for the addition of primary care services.

- BH Integration Referral Incentive: Humana will incentivize BH providers to connect their patients with primary care. [REDACTED]
- Practice transformation incentive (PTI): Humana will offer a one-time transformation incentive to our PCPs and BH providers to support provider-initiated actions that improve integration of services. In other states, network providers have chosen to use this incentive to support hiring a BH provider in primary care settings (or PCPs in a BH setting) and to establish telehealth equipment.
- Care coordination fee: Humana currently provides a care coordination Per-Member-Per-Month (PMPM) fee to the Kentucky Primary Care Association and its member Federally Qualified Health Centers (FQHC) to support delivery of care to Humana Enrollees, including closure of care gaps related to BH services.
- Patient-Centered Medical Homes: Providers in our network who have a minimum panel size of 250 attributed Enrollees and maintain PCMH certification will receive an additional care coordination fee to support more intensive patient management activities. From our experience establishing these arrangements within our Florida Medicaid plan, we recognize the ability of health homes, including Patient-Centered Medical Homes (PCMH), to promote integrated care for Enrollees with co-occurring conditions and address the SDOH needs of their patient panels. In addition, fully integrated health homes often have added CMs and Social Service Workers to help Enrollees navigate the healthcare system and support linkage with community resources. We will work with interested providers to encourage participation in the health home model, including certification as a PCMH.
- Full Value Model: In our Full Value program, Humana engages with providers in arrangements where providers fully coordinate and manage the cost of care. This may include a global capitation payment or other arrangements with downside risk. Through our extensive experience implementing full-risk arrangements in Florida, we have found that providers operating under the Full Value model have both the incentive and resources to ensure that our Enrollees are linked with BH services and SDOH resources.
- Provider training: Successful integration at the provider level depends on the availability of providers – both physical health and BH – who have the skills, knowledge, and training to screen, refer for, or provide integrated services. In addition to our standard provider education offerings, Humana offers our network providers access to our **Relias Provider Education eLearning Library**. Our library offers 343 modules targeted at both physical health and BH providers managing the care of Medicaid Enrollees. **Relias** modules are accredited by at least one professional organization and are eligible for continuing education (CE) credit. We made a concerted effort to include courses in our eLearning Library that build the capacity of our network PCPs to understand, screen for, and treat the BH needs most common in our Medicaid Enrollees.

a.ii.

Approach for coordination with carved-out services (e.g., transportation and transitions to long term supports and services).

CARE COORDINATION SUPPORT

Humana applies a proactive approach to coordination with carved-out services (services covered by Medicaid benefits but not managed by Humana). Our approach includes the following:

1. **Identification**: Through screening, assessment, and stratification, we identify Enrollees who may benefit from carved-out services; including transportation, 1915(c) waivers; certain early intervention (First Steps) services; school-based services; long term services and supports (LTSS); family preservation services; and equine, art, and music therapy.
2. **Referrals**: We coordinate appropriate referrals, including directly contacting the service provider or responsible agency if needed.

3. **Education:** Education and referrals for early intervention services and other Commonwealth-funded services [such as Women, Infants and Children (WIC) and Kentucky’s Health Access Nurturing Development Services (HANDS)] are routine parts of our maternity and Neonatal Intensive Care Unit (NICU) care management programs, recognizing that the populations targeted by these programs are the most likely to benefit from these offerings.
4. **Documentation:** We document information about receipt of carved-out services in the Enrollee’s care plan or CGX record (once aware of their participation). This documentation allows Humana associates and any providers interacting with the Enrollee to be aware of the range of Medicaid services provided to the Enrollee, to anticipate any gaps in service coverage, and to coordinate with the responsible service providers, as needed. We also coordinate the provision of medical information as requested by WIC and in compliance with applicable law.

Enhancing School-Based Services
Humana is supporting the advancement of Norton Healthcare’s school-based telemedicine program in Jefferson County Public Schools. Humana will sponsor the telemedicine technology that Norton Healthcare uses to remotely examine the student with the assistance of the school nurse. This support will allow expansion of telemedicine technology in public schools located in underserved areas, reducing disparities in access to care while improving the overall health of the community.

Table I.C.20-1 summarizes Humana’s approach to the coordination of carved-out services, including transportation, 1915(c) waivers and long term services and supports, certain Early Intervention (First Steps) services, school-based services, family preservation services, and forms of therapy not covered by Medicaid managed care (including equine, music, and art therapy).

Table I.C.20-1: Humana’s Approach to Coordination of Carved-Out Services

Name	Care Coordination Support
Transportation	<ul style="list-style-type: none"> • Provision of educational materials regarding the availability of transportation services and Enrollee referrals, as appropriate • Referrals for transportation services during welcome calls and outbound call campaigns to close gaps in care • Routine evaluation of Enrollee transportation needs during the HRA, Enrollee Needs Assessment, post-discharge planning, routine care management contacts, and inbound and outbound Member Services calls • Documentation of transportation needs and referrals to transportation services in Enrollee care plans (as applicable) • Education on how to submit a request for Non-Emergency Medical Transportation (NEMT) through the Kentucky Transportation Cabinet, delivered by our SDOH coordinators, CMs, CHWs, and MSRs
1915(c) Waivers and Long Term Services and Supports	<ul style="list-style-type: none"> • Educating potentially eligible Enrollees on the availability of 1915(c) waivers and assisting with referrals, as desired • Upon notification that the Enrollee is transitioning out of managed care upon receipt of a 1915(c) waiver, a long-term stay (greater than 30 days) in a Nursing Facility (NF), or another service that makes them ineligible for managed care, our CM contacts the Enrollee or their representative to discuss the transition • Provision of support and oversight (as needed) to ensure the Enrollee’s case is successfully transitioned to the fee-for-service delivery system and that there is no interruption in medically necessary services up to the effective date of transition • Contacting the Enrollee’s new CM (if assigned and with the Enrollee’s agreement) to provide information about existing services and transfer records

Table I.C.20-1: Humana’s Approach to Coordination of Carved-Out Services

Name	Care Coordination Support
<p>Certain Early Intervention (First Steps) Services</p>	<ul style="list-style-type: none"> • Educating mothers-to-be and parents of newborns about First Steps through our MomsFirst and NICU care management programs • Upon identification of an Enrollee as a possible candidate for First Steps (through the Enrollee Needs Assessment, provider referral, complex care management, or another route), our CMs help the Enrollee’s caregiver contact their local point of entry office for First Steps. We follow up with the caregiver of the referred Enrollee to ensure they have linked with the appropriate First Steps office. • Document receipt of First Steps services on the Enrollee’s care plan (if engaged in our Management of Chronic Conditions or Intensive/Complex Care Management program) • With the permission of the Enrollee’s representative, share the Enrollee’s care plan with First Steps to promote coordination of services and continuity of care once the Enrollee’s eligibility for First Steps ends, including coordinating the transfer of medically necessary services to network providers. • Attend meetings organized by First Steps providers, as invited
<p>School-Based Services</p>	<ul style="list-style-type: none"> • Educate identified Enrollees on the availability of school-based services from which they benefit, including Individualized Education Plans, and facilitate appropriate referrals (as desired by the Enrollee and their caregiver) • Document the content of Enrollees’ Individualized Education Plans in our system, as Humana is responsible for coverage of the Individualized Education Plan services during school breaks • With the permission of the Enrollee’s legally authorized representative, share the care plan with their current school to assist in coordination of school-based services
<p>Family Preservation Services</p>	<ul style="list-style-type: none"> • Identifying children at risk for out-of-home placement through the Enrollee Needs Assessment, as well as reviewing claims for Enrollees with serious emotional disturbance, as they are at a higher risk for out-of-home placement • For identified children and families, coordinate with providers of family reunification services and support other activities under the Family First Prevention Services Act • Humana has established a relationship with KVC Kentucky to deliver services and interventions to identified children and families, including offering parenting classes and appropriate therapies to parents
<p>Equine, Art, and Music Therapy</p>	<ul style="list-style-type: none"> • Coordinate with diagnosis-specific advocacy groups to arrange non-covered therapy services (e.g., equine, art, and music therapy) when our CMs identify an Enrollee who may benefit from these supports

EDUCATION FOR ENROLLEES ON CARVED-OUT SERVICES

Our Enrollee Handbook and Enrollee website describe carved-out services and provide referral information. In addition, we train all of our MSRs on referral procedures for carved-out services to assist inbound callers, and our CMs are additionally trained on eligibility criteria so they may identify and refer eligible Enrollees for services such as those covered under 1915(c) waivers.

EDUCATION FOR PROVIDERS ON CARVED-OUT SERVICES

We help our providers understand services covered by managed care (and those that are carved out) to expedite appropriate referrals for our Enrollees. Information on all covered services is available via the Provider Manual and online through Humana’s Availity system. Additionally, our Provider Relations representatives are a direct resource to our providers on covered and non-covered services and value-added services for Enrollees and can answer questions providers have on carved-out services.

a.iii. A description of any value-added services the Vendor proposes to provide to Enrollees.

Humana’s value-added services are designed to improve Enrollee outcomes through expanded benefits that address our Enrollees’ physical health, BH, and SDOH needs. To develop this list, we added innovative industry offerings and effective value-added services from our market Medicaid plans to current value-added services offerings for our Kentucky Medicaid Enrollees.



Table I.C.20-2: Humana’s Value-Added Services

Name	Scope	Eligible Populations	Service Limit	Target Outcome
Adult preventive dental services	One additional cleaning per year	Enrollees ages 21+	One additional cleaning per year	Decrease in dental-related complications, as well as associated inpatient and emergency department (ED) visits
Adult vision services (glass/frames)	Annual eye exams and glasses every 24 months	Enrollees ages 21+	One eye exam per year One pair of glasses every two years	Improved detection of vision-related diseases, decrease in associated vision loss, and decrease in injuries associated with poor vision
Gift card program	Incentives for preventive care, including screenings and prenatal and postpartum services, completion of the HRA, and completion of appropriate level of care training	All Enrollees	One incentive per Enrollee for each program annually	Increase in measures associated with preventive care and decrease in unnecessary emergency department (ED) visits
Tobacco cessation	Craving to Quit	Enrollees ages 12+	Unlimited	Decrease in incidence of tobacco-related diseases
Criminal record expungement	Cost of criminal record expungement (\$500 per Enrollee)	Enrollees ages 21+	One per Enrollee per lifetime	Increased access to employment opportunities and associated financial stability
GED	GED test preparation assistance, including a bilingual advisor, access to guidance and study materials, and unlimited use of practice tests. Test preparation assistance is provided virtually to allow maximum flexibility for Enrollees. Also includes test pass guarantee to provide Enrollees multiple attempts at passing the test.	Enrollees ages 18+	Unlimited access	Increased access to employment opportunities and associated financial stability

Table I.C.20-2: Humana’s Value-Added Services

Name	Scope	Eligible Populations	Service Limit	Target Outcome
Child care assistance	\$40 per quarter toward child care expenses for caretakers seeking employment opportunities	Enrollees ages 21+	\$40 per quarter (four times per year)	Increased access to employment opportunities and associated financial stability
Adult immunization	Free flu shots and immunizations for hepatitis B, meningococcal disease, rotavirus, pneumococcal disease, rabies, tetanus, diphtheria, varicella, hepatitis A, polio, and haemophilus influenza type B	Enrollees ages 21+	One vaccine or immunization per Enrollee based on periodicity schedule	Decrease in preventable inpatient admissions, ED visits, and outpatient visits associated with vaccine-preventable diseases
Mobile phone services	Unlimited Tracfone data and minutes for Enrollees who are experiencing homelessness, are pregnant, or are engaged in care management	Enrollees ages 18+	One per household	Increase appropriate use of care among target populations through better communication with providers and CMs and access to community resources and Humana digital solutions
Portable crib	Portable crib as an incentive to attend at least seven prenatal visits	Pregnant Enrollees who complete at least seven prenatal visits	One per Enrollee per pregnancy	Increase in timeliness of prenatal care
Smartphone application for prenatal care, breastfeeding, and newborn /infant care assistance	Access to Pacify, a smartphone application that provides access to video chat with a lactation consultant, or a phone call with a physician extender or RN, for on-demand assistance 24 hours a day, 7 days a week	Pregnant Enrollees and Enrollees with a child up to one year of age	Unlimited	Increase in exclusive breastfeeding rates and decrease in preventable ED visits
Smartphone application for diabetes management	Access to BlueStar, an innovative digital therapeutic smartphone application for diabetes management	Enrollees with diabetes	Unlimited	Decrease in preventable inpatient and ED visits associated with diabetes care
Non-pharmacological pain management alternatives	Chiropractic care and acupuncture care	Enrollees ages 21+ with chronic pain	Up to 365 visits per year, across all three services	Decrease in use of opioids for pain management

Table I.C.20-2: Humana’s Value-Added Services

Name	Scope	Eligible Populations	Service Limit	Target Outcome
Unlimited home visits for high-risk pregnant Enrollees	Delivery of in-home maternity services for high-risk Enrollees when medical conditions do not allow travel to/participation in normal office-based care	Pregnant Enrollees identified as high risk	Unlimited	Increase in timeliness of prenatal care and decreases in preterm birth, low birthweight births, NICU admissions, and infant and maternal mortality
Sports physicals	One sports physical per year for Enrollees ages 6-18	Enrollees ages 6-18	One per year per eligible Enrollee	Increase in access to PCP care and improved screening and treatment of childhood conditions
Post-discharge meals	Up to 10 home-delivered meals following discharge from an inpatient or residential facility	Enrollees being discharged from an inpatient or residential facility	40 meals per year	Decrease in readmission rates
Doula services	Doula assistance during labor and delivery to provide emotional and physical support to the laboring mother and her family	Pregnant Enrollees	Two Prenatal visits, two Postpartum visits and one visit for delivery assistance	Improved birth outcomes, including decrease in C-section rates and complications from delivery
myStrength	Access to myStrength, a digital solution designed to improve self-management of BH and physical health conditions, including depression, anxiety, insomnia, chronic pain, and postpartum depression, using online learning, self-help tools, wellness resources, and text-based one-on-one coaching	Enrollees ages 13+	Unlimited	Decrease in costs and utilization associated with unmanaged BH conditions, including effects on Enrollee physical health and decrease in use of opioids for pain management

b.

Provide the Contractor's approach to assisting Enrollees to access direct access services and second opinions, and referrals for services not covered by the Contractor

Humana's approach to coordinating services focuses on ensuring that Enrollees receive all medically necessary services in a timely manner in the most appropriate setting.

ACCESSING DIRECT ACCESS SERVICES

In compliance with Section 30.2 of the Draft Medicaid Contract, Humana will ensure that our Enrollees can access all Covered Services. We train our associates to assist our Enrollees in accessing Covered Services. If an in-network provider cannot be located to provide a covered service, our associates help the Enrollee locate an out-of-network (OON) provider and obtain a prior authorization (PA) request from their PCP.

Our Kentucky Medicaid Provider Services staff (led by Majid Ghavami and Michelle Weikel) reviews all instances of Enrollees accessing an OON provider for a covered service or a direct access service. We contact high-volume OON providers to determine if they are qualified and interested in enrolling in the Humana network. We also contact all OON providers who have provided a direct access service to our Enrollees to determine if they are qualified and interested in enrolling in our network.

We educate our Enrollees about direct access services and inform them of their choice of a qualified provider. We include this information in our Enrollee Handbook.

Primary care vision services: Humana – together with our vision services partner, Avēsis – promotes access to primary care vision services among eligible Enrollees through Enrollee education campaigns promoting vision screenings on their own and as part of each initial and periodic Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings. In addition, we will promote the American Academy of Pediatrics (AAP) standards for preventive pediatric healthcare to ensure provision of routine vision screenings among Enrollees under the age of 21. To ensure receipt of glasses or other necessary vision services upon a positive vision screen, we will review Enrollee files to identify those with a positive vision screen and monitor claims for evidence of receipt of vision care. If the Enrollee does not receive the recommended vision services within two months after a positive screening, we will queue them for an outbound call for assistance in scheduling an appointment with an optometrist, ophthalmologist, or optician.

Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists: We view dental care as an essential part of health and well-being. **In 2018, 74.4% of Humana Medicaid eligible Enrollees received a dental service, far exceeding the Kentucky rate of 51.2% and the national rate of 49.6%.** Working with our dental services provider, Avēsis, we conduct quality campaigns to target gaps in dental care among Enrollees of all ages and encourage our Enrollees to have a dental home. We describe the success of one of these campaigns in the text box below.

In 2017, Avēsis instituted an initiative to improve the annual dental visit (ADV) rate for Humana Kentucky Medicaid Enrollees. Data analysis revealed 7,068 Humana Enrollees in Regions 3 and 5 who had not had a dental visit since January 2016. Over the course of the intervention, we successfully contacted 20% of the non-compliant households by phone (1,021). As a result of these calls, 6.8% of the non-compliant Humana Enrollees successfully completed a dental visit, contributing to a 2.8% bump in the statewide ADV rate.

Voluntary family planning: Humana places a strong emphasis on educating our Enrollees on the importance of and their right to confidentially seek family planning services through Enrollee materials emphasizing that they may also self-refer to a qualified family planning provider not in our network. We check for documentation of family planning counseling in our PCP chart audits. Our communications clearly inform Enrollees that we cover the full scope of family planning methods, services, counseling, and follow-up care.

Humana encourages access to long-acting reversible contraceptives (LARC). In 2017, 1,699 LARCs were placed, and in 2018, 1,644 LARCs were placed.

Enrollees can seek these services from an in-network or OON provider, without a referral from their PCP; these services are confidential for all Enrollees, including those who are under 18 years of age. Humana’s Enrollee education and outreach activities focus on the importance of family planning and birth spacing for maternal and child health. Our outreach activities include Enrollee education materials, MomsFirst, health fairs, community events, and campaigns. We also work with local community resources to maximize Enrollee education on how to obtain contraceptives and broader family planning services. We collaborate with community agencies and our OB/GYN providers to develop positive family planning education and practices among our Enrollees.

Maternity care for Enrollees under 18 years of age: Humana’s primary goal for providing perinatal services is delivering proactive care to positively impact the health outcomes of pregnant and newborn Enrollees. We emphasize early identification of pregnant Enrollees through our welcome calls, review of claims (including pharmacy data), notification of the pregnancy incentive for our providers, and Enrollee education encouraging pregnant Enrollees to reach out to Humana for additional services and support. Once we identify a pregnant Enrollee, our MomsFirst care management program initiates contact to ensure the Enrollee is receiving prenatal care and to invite her to participate in care management, whatever her risk level. If the Enrollee has not made an appointment with an OB/GYN, our MomsFirst associate helps her find an OB/GYN in her area. In addition, we educate the Enrollee on available incentives for prenatal and postpartum care to encourage attendance at all recommended appointments.

Immunizations to Enrollees under 21 years of age: Through our quality monitoring and reporting systems – including monthly HEDIS reports to providers – we will track gaps in recommended immunizations among our Enrollees under 21 years of age. We use back-to-school and seasonal outreach campaigns to encourage routine immunizations. In addition to encouraging immunizations at their PCP’s office, we will inform Enrollees that they may use other healthcare sites to receive these immunizations without a PCP referral. We will review data from the Kentucky Immunization Registry to ensure that we are capturing immunization data for our Enrollees from in-network and OON providers and maintain an up-to-date immunization record. **Figure I.C.20-2** shows a page from our Fall 2018 Enrollee newsletter, promoting access to vision, dental, and immunization services.

Sexually transmitted disease (STD) screening, evaluation, and treatment: When featuring communications on STD screening, evaluation, and treatment in our Enrollee informational materials – including our Enrollee Handbook and any quality campaigns targeting chlamydia screening in female Enrollees ages 16-24 – we will emphasize direct access provisions.

Figure I.C.20-2: A page from our Fall 2018 Enrollee Newsletter



Tuberculosis screening, evaluation, and treatment: Humana understands the importance of providing timely services and ensuring Enrollees with tuberculosis (TB) are compliant with treatment protocols. Humana will work with providers and Enrollees to educate them on prevention, detection, and effective treatment of the disease, including their ability to utilize these services without a PCP referral. Our CMs will identify Enrollees who may be or are at risk of TB, in part, through risk factors (e.g., a diagnosis of AIDS), behaviors, drug resistance, and environmental conditions and help the Enrollee connect with needed services.

Testing for HIV, HIV-related conditions, and other communicable diseases: We will promote HIV screening and screening for other communicable diseases (e.g., hepatitis C) among high-risk Enrollees, including Enrollees who inject drugs. From our experience serving Enrollees with HIV/AIDS in other markets, we recognize the challenges in successfully reaching this population. Therefore, we have deemed HIV/AIDS a priority condition for our Kentucky Medicaid population and have made persons who inject drugs a priority population. We will partner with community organizations serving individuals with HIV, individuals at-risk of HIV, and individuals with behaviors that put them at risk of other communicable diseases (e.g., persons who inject drugs) to successfully connect with Humana Enrollees and explain our direct access policy to encourage appropriate testing for HIV, HIV-related conditions, and other communicable diseases. To ensure continued use of these services, we will also engage identified Enrollees with HIV/AIDS and persons who inject drugs in our PHM programs.

Chiropractic services: We will cover chiropractic care both under the capitated Medicaid benefit and as a value-added service for Enrollees with chronic pain who require more than the 26 covered sessions per year.

Direct access to a specialist for Enrollees with special health care needs: Through our experience serving Medicaid Enrollees with complex needs, we recognize that Enrollees with special health care needs often require specialist care. Our CMs link these Enrollees with our network of specialists to find one who meets their needs.

Women's health specialists: Humana is committed to women's health, including the prevention and treatment of conditions such as breast cancer and cervical cancer. We will promote screening for these conditions through our Enrollee incentives and will highlight our direct access policy for women's health specialists in regular Enrollee communications to encourage them to visit an OB/GYN or other specialist for their healthcare services, if preferred.

SECOND OPINIONS

We inform our Enrollees about their right to a second opinion about their treatment, including surgical procedures and treatment of complex or chronic conditions, through our Enrollee Handbook. In the handbook, we emphasize their right to seek an opinion from an in-network or OON provider. In addition, our MSRs can guide the Enrollee through the process, including helping them obtain a PA request for a second opinion from an OON provider and coordinating the transfer of laboratory tests and other diagnostic procedures to the provider giving the second opinion. Enrollees are entitled to a second opinion even without the perception that the first provider gave substandard care. It is also our policy to permit access to a third opinion, without PA, as long as the provider is in-network.

REFERRALS FOR SERVICES NOT COVERED BY HUMANA

When we determine that an Enrollee needs a Medicaid service that is outside the scope of Covered Services provided by Humana, we help the Enrollee locate a provider enrolled in the Medicaid FFS program that can provide the requested service. Once we identify the provider, a Humana CM helps the Enrollee access the service or, if appropriate, transitions the Enrollee's care to the Medicaid FFS provider, including contacting the Enrollee's existing providers to establish a medical history and active courses of treatment and communicating this information to the FFS provider.

We uphold our Enrollees' right to change their PCP for cause, including instances in which the Enrollee does not have access to providers qualified to treat their healthcare needs. If the Enrollee does request PCP reassignment

for this reason, our MSRs can guide them through the process for PCP reassignment. If approved, the assignment goes into effect no later than the first day of the second month following the month of the request.

c. Describe the Vendor’s proposed approach to the following:

c.i. Interfacing with the Department and Department for Behavioral Health, Developmental, and Intellectual Disabilities.

Humana will continue to partner with the Department and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to address issues of importance to the Commonwealth, our provider community, our Enrollees, and our communities, in adherence with requirements in Section 30.7 Interface with State Behavioral Health Agency of the Draft Medicaid Contract. In addition to contributing our experience and expertise to those topics of concern to the Department and DBHDID, we will come prepared with other suggestions for topics that may be of importance to the Department, DBHDID, and other Managed Care Organizations (MCO).

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES (DMS)

Humana is committed to interfacing with the Department through monthly meetings, required reporting, ad hoc exchange of information via e-mail or other communications, or in any other way deemed fit by the Department. Our Kentucky Medicaid managed care plan leadership – including Lisa Galloway, MD, our Medical Director; Joseph Vennari, PharmD, our Pharmacy Director; Audra Summers, MSN, RN, our Quality Improvement Director; Adrienne McFadden, MD, JD, our PHM Director; Kathy Kauffmann, RN, our UM Director; Dr. Jerry Caudill, DMD, our Dental Director; and Liz Stearman, CSW, MSSW, our BH Director - are available for monthly meetings and other Departmental communications, with the assistance of other Humana associates or subcontractor associates as needed or requested.

As a long-time partner of the Department, Humana has had the opportunity to interface with the Department, sister agencies, and other MCOs on topics important to our Enrollees and providers. For example:

- **Pharmacy Policy:** Humana and our PBM, HPS, worked with the Department and other MCOs to determine how to best implement the pricing requirements of Senate Bill 5.
- **Psychotropic Use:** We have discussed how we can better manage and serve children using BH medications with the Department for Community Based Services (DCBS). We contributed our own practices related to pharmacological management and data on utilization of in-home services, neuropsychological testing, and providers of applied behavior analysis services.
- **Re-Entry Pilot Program:** Acknowledging the barriers to accessing BH services that incarcerated Enrollees face upon release from prison and the higher risk of recidivism if they are not connected to appropriate care, Humana supports the Commonwealth’s re-entry pilot program by providing integrated care management services to our Enrollees recently released from a correctional facility. Humana actively supports this collaborative pilot between DMS, DBHDID, and the Department of Justice (DOJ) to support recently incarcerated individuals, and looks forward to continuing this collaboration as the Cabinet for Health and Family Services (CHFS) and DOJ expand it to new correctional facilities this year. Humana supports this program by ensuring our Enrollees are immediately connected to a dedicated CM, PCP, and community mental health center (CMHC) upon their release from prison. Humana has designated a CM who is responsible for outreach to all recently incarcerated Enrollees identified under this pilot, ensuring that our Enrollees are served by someone knowledgeable of and familiar with the circumstances of their release and the systems available to support them. Our CMs ensure the Enrollee has all relevant Enrollee materials, understands all aspects of their plan, and receives services and prescribed medications, with the ultimate goal of preventing and reducing recidivism.

We aim to continue conversations like these with the Department and its sister agencies in the future and on a range of topics that affect our Enrollees.

DEPARTMENT FOR BEHAVIORAL HEALTH, DEVELOPMENTAL AND INTELLECTUAL DISABILITIES

Liz Stearman, our Kentucky Medicaid BH Director, meets with DBHDID at least quarterly to discuss items including, but not limited to:

- State Mental Health Authority Agency protocols, rules, and regulations
- Targeted care management, Community Support associates, and Peer Support Provider certification training and process
- Enrollee education for individuals with serious mental illness (SMI), children and youth with serious emotional disturbance (SED), and other priority populations
- Provider, associates, and staff training (to include thirty-party subcontractors when appropriate) on priority training topics, such as suicide prevention and trauma-informed care
- Satisfaction survey requirements
- A process for integrating our BH Crisis Line and services with the Department, DBHDID, and CMHCs
- Establishing collaborative agreements with State-operated or State-contracted psychiatric hospitals, as well as other Department facilities that individuals with co-occurring BH and intellectual and developmental disabilities (BH/IDD) use

Our BH Director Liz Stearman will include other Humana associates, including Dr. Lisa Galloway, our Kentucky Medicaid Medical Director, and Dr. Adrienne McFadden, our PHM Director, in meetings with DBHDID (as permitted) to discuss topics of interest. Our BH Director Liz Stearman and other associates will also be available for other ad hoc engagements with DBHDID.

Outside of these quarterly meetings, Humana has closely collaborated with DBHDID on a number of initiatives. We intend to continue these partnerships while looking for additional avenues of collaboration and leverage our standing meetings to discuss agenda items that respond to the priorities of DBHDID and Humana. For example:

- **Opioid Use Disorder:** Humana is committed to partnering with the Commonwealth to address opioid misuse. To support access to Medication Assisted Treatment (MAT), Humana has waived PA for preferred MAT therapies and associated services. In addition, we participate in agency-hosted webinars, conduct provider education, and encourage providers to enroll in the Commonwealth's certification program. We are also a participant in Kentucky's Recovery-Oriented System of Care meetings, and look forward to more actively partnering with the Commonwealth to expand access to a full continuum of high-quality, evidence-based opioid use disorder prevention, treatment, and recovery support services. In particular, we would like to explore how we can best work with the **Kentucky Opioid Response Effort** led by DBHDID. For example, our ability to collate and analyze data on a massive scale will enable the Commonwealth to identify gaps in service and areas for improvement in the delivery of opioid use disorder services under the Kentucky Opioid Response Effort. In addition, we intend to **provide scholarships for the education and training of 50 Adult, Family, Youth, and Registered Alcohol and Drug Peer Support Specialists**. We will also support any efforts by the Commonwealth to certify all residential SUD providers.
- **Support for Pregnant Women with SUD:** We will pursue a partnership with the DBHDID and CMHCs on the KY-Moms Maternal Assistance Toward Recovery (MATR) program, including opportunities to coordinate the activities of our maternity care management program, MomsFirst, with KY-Moms MATR. We believe that this coordination can optimally support our pregnant Enrollees with SUD and other dependencies (e.g., tobacco and alcohol) and reduce duplication of efforts. We will integrate referrals for KY-Moms MATR into our standard care management procedures for Enrollees who may benefit from the program's additional supports.

c.ii.

Coordinating with the Department to establish collaborative agreements with state operated or state contracted psychiatric hospitals and other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use. Describe potential challenges and methods to address such challenges.

APPROACH TO ESTABLISHING COLLABORATIVE AGREEMENTS

Humana has contracts in place with all psychiatric hospitals and distinct part units in the Commonwealth, including Appalachian Regional Healthcare, Eastern State Hospital, Central State Hospital, Western State Hospital, Baptist Health, and Universal Health Services facilities. As we enter the new Contract period, Humana will work with the Department to establish collaborative agreements with these institutions and other State-operated or State-contracted facilities that serve individuals with co-occurring BH and intellectual and developmental disabilities (BH/IDD), including inpatient psychiatric facilities and intermediate care facility specialty clinics. In establishing these agreements, we will emphasize avoidance of inappropriate institutionalization for this population, assistance in transitioning individuals with co-occurring BH/IDD to the least restrictive setting, and provision of appropriate services while Enrollees are residing in or receiving services from the facility.



During our conversations with these facilities, we learned of the current challenges faced by the BH/IDD delivery system in Kentucky. We view these collaborative agreements as an opportunity to leverage the capabilities of both Humana and the facility, including coordinating care management supports and data sharing. In establishing these agreements, we will seek to incorporate the priorities of the Department and the facility in serving individuals with co-occurring BH/IDD. We also aim to bring our relationships with community resources that have experience serving individuals with co-occurring BH/IDD into the conversation, including organizations employing Peer Support Specialists, recognizing their importance in avoiding inappropriate institutionalization and helping individuals transition to community-based care.

To support ongoing collaboration, we will invite a representative of State-operated and State-contracted facilities to join our Kentucky Medicaid Provider Advisory Committee.

POTENTIAL CHALLENGES AND METHODS TO ADDRESS SUCH CHALLENGES

Through our conversations with our BH providers across the Commonwealth, we have identified both challenges faced by the current delivery system in serving individuals with SMI and co-occurring BH/IDD, as well as potential challenges in developing collaborative agreements with State-contracted and State-operated facilities. We describe both in **Table I.C.20-3**.

Table I.C.20-3: Potential Challenges and Methods to Address Such Challenges

Potential Challenge	Method to Address
Payment limitations on Institutions for Mental Disease (IMD)	State-operated or State-contracted inpatient psychiatric facilities are IMDs, restricting their payment for care administered after a 15-day stay. To address the issue of uncompensated care, Humana will review our payment model for inpatient psychiatric care to develop alternative payment models (APM) that better address patterns of care at these facilities.
Gaps in discharge planning	Gaps in current discharge planning processes frequently mean that individuals with SMI and IDD have insufficient services in place when they leave the facility. To improve discharge planning, Humana will work with these facilities to allow our UM and CM associates to provide discharge planning support onsite and to ensure continuity of care as the Enrollee transitions to a lower level of care. This follows a model that we have applied to medical-surgical facilities through our Medicare plan in Kentucky and our Medicaid plan in Florida, and plan to extend to medical-surgical facilities under our Kentucky Medicaid Managed Care plan. We have also designated a CM who is a Licensed Clinical Social Worker to support all Humana Enrollees discharged from a State-operated or State-contracted psychiatric hospital.
Emphasis on BH provider-led transition planning	<p>The Draft Medicaid Contract emphasizes the role of BH service providers in discharge planning. Our VBP model incentivizes BH providers for their performance on the metrics related to follow-up after hospitalization and follow-up after ED visits. Our Transition/UM coordinators and CMs will continue to work closely with our BH providers throughout the discharge planning process, including sharing of discharge assessments and plans and coordination of follow-up appointments, physical health services, dental services, and community requirements to address health-related social needs. We are in active discussions with KARP, Inc. regarding a proposal to pay a Per Member Per Month (PMPM) care coordination fee to its member CMHCs. In addition to supporting closure of care gaps, this fee will give our providers the additional resources needed to support administrative and care coordination tasks, including discharge planning. If successful, we will look to expand this model to our other network BH providers.</p> <p>We will also explore the opportunity to provide a bundled payment to CMHCs to support the provision of High Fidelity Wraparound services. In our communication with BH providers, we have learned that funding presents a hurdle to the provision of this important, evidence-based service to Medicaid Enrollees. We intend for this bundled payment to lessen this burden and promote the delivery of High Fidelity Wraparound supports to our child and adolescent Enrollees with BH needs.</p>
Unique circumstances of each facility	Each facility serving individuals with co-occurring BH/IDD needs will have unique financial, geographic, staffing, and other characteristics to consider in developing collaborative agreements. Rather than applying a one-size-fits-all agreement across all facilities, we propose working with each facility to determine how the agreement can best meet their needs and capacity. For example, our CMs assigned to each facility will work with the relevant staff to develop and implement discharge planning procedures that fit with their existing capabilities and arrangements, while ensuring compliance with the Olmstead Act and all related Contract provisions.
Managing agreements with multiple MCOs	Humana understands that managing multiple agreements with MCOs can place a burden on our network providers. Therefore, we propose collaborating with other MCOs (as well as the Department) when establishing these agreements to align on processes and agreement language whenever possible.

Table I.C.20-3: Potential Challenges and Methods to Address Such Challenges

Potential Challenge	Method to Address
Coordination with carved-out services	A transition from an institutional setting to the community for an individual with co-occurring BH/IDD requires coordination across multiple providers and service systems, including the Medicaid fee-for-service system for long term services and supports. According to a 2018 CHFS report, there are approximately 8,600 individuals with IDD on waiting lists for the Supports for Community Living Waiver and Michelle P. Waiver, indicating that many individuals with BH/IDD transitioning out of an inpatient psychiatric facility will be eligible for managed care upon discharge when they may otherwise be eligible for waiver services. To facilitate this process, we propose involving the Department for Aging and Independent Living (DAIL) in conversations concerning discharge planning for waiver-eligible Enrollees.
Establishing collaborative agreements with non-participating facilities	Individuals with co-occurring BH/IDD residing in a psychiatric inpatient facility or receiving services from a specialty clinic may be eligible for Medicaid managed care, while those residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) or NF for longer than 30 days are ineligible. However, these individuals may become eligible for Medicaid managed care upon transition to the community. Therefore, we propose establishing collaborative agreements with these facilities to promote transition planning and continuity of care (particularly for individuals with a positive Pre-Admission Screening and Resident Review Level II result), even though they do not currently hold contracts with Medicaid managed care. We will consider possible inexperience coordinating with managed care and will factor education on managed care processes into our agreement discussions with these facilities.

c.iii. Complying with the Mental Health Parity and Addiction Equity Act.

Humana is committed to ensuring the Final Medicaid/Children’s Health Insurance Program (CHIP) Parity Rule (“Final Rule”) requirements are embedded throughout all Humana Medicaid operations. Humana understands that the Final Rule requires that the states, or the MCO (if the MCO is conducting the parity analysis) must perform an analysis of limits on mental health and substance use disorder (MH/SUD) benefits that involve financial requirements, quantitative treatment limitations (QTL) and aggregate lifetime or annual dollar limits. Humana is prepared to perform such analysis, if necessary, in collaboration with the Commonwealth and follow the required two-step parity analysis testing to determine the predominant financial requirement by type applied to substantially all medical/surgical (M/S) benefits in the defined classifications prescribed by the Commonwealth.

Humana utilizes the formulas and grids from the *CMS Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children’s Health Insurance Programs* to measure and track compliance for quantitative and non-quantitative treatment limitations, with a particular focus on the actuarial formulas for the quantitative treatment limitation analysis and the comparative analysis grid for the non-quantitative treatment limitations.

Under the Final Rule, a non-quantitative treatment limitation (NQTL) is a limit on the scope or duration of benefits. Humana’s processes, strategies, evidentiary standards, or other factors used in applying NQTLs to MH/SUD in a classification are designed to be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in such classification in accordance with Final Rule. Humana has instituted processes, controls, and governance to set and monitor compliance with NQTLs. Below is a summary of Humana’s NQTLs, including, but not limited to:

- Medical necessity standards: Humana applies nationally recognized clinical criteria standards to both BH and physical health determinations. Humana makes the criteria for medical necessity determinations with respect to MH/SUD benefits available to any current or potential participant, Enrollee, or contracting provider upon request.
- Prior or ongoing authorization requirements: Humana's prior authorization program promotes the efficient delivery of quality, optimal, and appropriate treatment options for our Enrollees across both M/S and MH/SUD services. Our Prior Authorization List (PAL) team includes both Medical Directors and Behavioral Health Medical Directors. Humana uses specific metrics to determine whether to include a requested M/S or MH/SUD service in the PAL, including, but not limited to:
 - Overutilization, underutilization, and inappropriate utilization
 - Potential quality of care issues
 - Trends of services not meeting nationally recognized, evidence-based criteria for medical necessity
 - Current claims volume for the service
 - Projected Enrollee impact
 - Potential provider impact
 - Cost per episode
 - New/emerging technology
- Utilization review requirements: Humana utilizes MCG guidelines for both physical health and BH determinations, providing a basis for consistent decision-making. In compliance with Contract requirements, we will apply American Society of Addiction Medicine (ASAM) guidelines for SUD services. Clinical reviews are managed within the parameters established by published National Committee for Quality Assurance (NCQA) guidance, as well as applicable State and federal regulatory requirements. To ensure we consistently apply review criteria for authorization decisions, Humana provides initial and ongoing education for our UM associates and network providers, including clinical practice guidelines, PALs, and determination of medical necessity. We perform inter-rater reliability studies of physician and non-physician reviewers at least annually, as well as monthly audits on UM associates, to ensure that criteria are applied consistently and are not more stringently applied to MH/SUD as compared to M/S benefits.
- Experimental and investigational definitions: Humana utilizes consistent definitions for experimental and investigation for both MH/SUD and M/S benefits.
- Pharmacy formulary design: Humana's Pharmacy and Therapeutics (P&T) Committee applies an evidence-based review process in developing the formulary and PA criteria, in compliance with the following guidelines:
 - The pharmaceutical must be approved for marketing by the FDA.
 - The pharmaceutical should reasonably improve the net health outcome. The pharmaceutical's known beneficial effects on health outcomes as demonstrated by the evidence review should outweigh any known harmful effects on health outcomes.
 - The improvement must be attainable outside the investigational setting.
- Denial Rationale: Humana informs providers and Enrollees of the clinical rationale used as the basis for a medical necessity determination in individual adverse determination letters.
- Providing OON coverage for M/S benefits and OON coverage for MH/SUD benefits: As medically necessary, Humana provides OON coverage for M/S and MH/SUD benefits. Enrollees and providers can follow the same process for requesting OON coverage whether the benefit is M/S or related to MH/SUD.

- d. Describe initiatives the Contractor will implement to identify trends in provider-preventable conditions and to educate providers who are identified as possibly needing support in better addressing those conditions.

Humana is acutely aware of the seriousness of patient safety and adverse events, including provider-preventable conditions. We have instituted policies and procedures designed to identify, investigate, report, and prevent provider-preventable conditions among our Kentucky Medicaid network providers. We require all providers treating Humana Enrollees to report provider-preventable conditions, including (at a minimum) the investigation of wrong surgical or other invasive procedures performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. Investigations of quality of care issues by a Humana UM nurse reviewer include a review of medical records to determine the severity of the issue. We will not pay for services associated with a provider-preventable condition, consistent with the criteria described in section 30.8 of the Draft Medicaid Contract. There were no provider-preventable conditions reported among our Kentucky Medicaid Enrollees in 2019.

IDENTIFYING TRENDS IN PROVIDER-PREVENTABLE CONDITIONS

We may identify provider-preventable conditions through multiple routes, including:

- Utilization review: Humana’s UM team is trained to make quality of care referrals in our Quality Management System when they identify suspected provider-preventable conditions or other issues that indicate a potential quality of care concern during prospective, concurrent, or retrospective utilization reviews.
- Claims data mining: Using hospital discharge abstract data, Humana reports and tracks 16 patient safety indicators developed by the Agency for Healthcare Research and Quality. In addition, we report and track three Serious Reportable Adverse Events, including hospital-acquired conditions and never events.
- Grievances and appeals: Any Enrollee or provider grievance that indicates a potential instance of a provider-preventable condition is referred to our Quality Operations Compliance and Accreditation (QOCA) team.
- Risk management: Our QOCA team works closely with Humana’s Risk Management department to investigate potential quality of care issues that have resulted from a critical incident.
- Care management: Our CMs are the first point of contact for many of our Enrollees. In the case that a provider-preventable condition is first reported to a CM by an Enrollee or their family, our CMs will relay this information to our QOCA team for follow up.
- Referral from a State or federal agency: Our QOCA team will open an investigation into any reports of a provider-preventable condition or other quality of care issue received from a State or federal agency.

Humana’s QOCA team is responsible for reviewing quality of care issues related to provider-preventable conditions. Examples of past provider-preventable conditions that we have identified include instances when an Enrollee returned to the operating room due to unexpected complications or when an Enrollee experienced unexpected post-operative complications.

Our Kentucky Medicaid Medical Director, Dr. Lisa Galloway, reviews all cases involving provider-preventable conditions with the nurse reviewer and will work with that nurse reviewer to determine next steps, which may include a referral to the Peer Review Committee (PRC). If referred, Dr. Galloway will present the case to the PRC, along with their recommendations. Humana’s PRC is responsible for reviewing potential quality of care issues, determining the severity of the issue, and recommending quality improvements or corrective actions as appropriate. In addition, the PRC is charged with developing individual provider quality improvement plans, where indicated, and reviewing progress toward resolution. Physicians and other healthcare professionals participate on the PRC, with only physician members having voting privileges. A Humana Medical Director chairs the PRC.

QOCA utilizes our Quality Management System database to document quality of care investigations and create trend reports. These reports include comparisons to measurable goals (e.g., timeliness of investigation), quarterly and annual trends in quality of care issues, and investigation results.

These reports are shared at least quarterly with the Kentucky Medicaid Quality Improvement Committee (QIC) to monitor and analyze quality of care issues and include any peer-recommended corrective actions taken and further recommendations. In addition, QOCA will provide a report of identified provider-preventable conditions in a form or frequency as specified by DMS. Our Credentialing Committee also reviews trend reports on potential and identified quality of care issues during the re-credentialing process.

EDUCATING PROVIDERS IDENTIFIED AS POSSIBLY NEEDING SUPPORT IN BETTER ADDRESSING THOSE CONDITIONS

QOCA refers any case of a provider-preventable condition to our PRC to determine next steps. Interventions may include:

- Provider education: We will offer education on corresponding clinical practice guidelines (CPGs) and evidence-based practices to prevent future quality of care issues.
- Institution of a corrective action plan (CAP): QOCA will monitor any instituted CAP to track progress against set goals throughout the implementation of the work plan and even after closing the CAP to ensure the solutions have appropriately addressed the issue. A CAP related to a provider-preventable condition may target changes in protocols, implementation of new or different technologies, or revised trainings. Providers who fail to correct issues contributing to the provider-preventable condition will be subject to further disciplinary action, up to and including termination from the network.
- Focused review: If the provider has exhibited a trend of provider-preventable conditions or other quality of care concerns, QOCA may recommend to the PRC or our QIC that we undertake a focused review of the provider to determine further interventions or potential adverse actions.

In addition to offering education to providers identified as possibly needing support in better addressing those conditions, we will also monitor trends in provider-preventable conditions to inform educational strategies across our network, including promotion of guidance published by the National Quality Forum. We will also leverage learnings from investigations into provider-preventable conditions to disseminate best practices across our network, including recommended trainings or protocols.