

C. Technical Approach

24. Population Health Management (PHM) Program
(Section 34.0 Population Health Management Program)

a. Provide a comprehensive description of the Contractor's proposed Population Health Management (PHM) Program, including the following at a minimum:

Population health is a foundational element of Humana's enterprise mission and a core component of our managed care programs. We assess our Enrollees to identify needs and preferences, employ strategies to improve health and well-being, and implement interventions for priority populations, Enrollees with emerging risks and significant behavioral health (BH) and Social Determinants of Health (SDOH) issues, and segments of our population experiencing health disparities. Our continuous quality improvement methodology measures data, tracks trends, and monitors outcomes to adjust our approach and achieve the Triple Aim – better health, better care, better value.



Humana currently serves more than 615,000 Medicaid Enrollees in Kentucky, Florida, and Illinois. Our Medicaid presence in the Bluegrass State since 2013 – combined with Humana's establishment in the Commonwealth in 1961, management of more than 145,000 Kentucky Medicaid Enrollees currently, our Louisville-based corporate headquarters and executive leadership team, and more than 12,000 Humana associates residing in the state and 25 local offices – positions us to be an ideal and dedicated partner to the Department for Medicaid Services (DMS) in our commitment to transform population health outcomes for Kentuckians.

a.i. Innovations and program elements the Contractor proposes to incorporate into this Program to support the overall goals of improving health outcomes for the population and empowering individuals to improve their health and engage in their healthcare.

KEY PROGRAM ELEMENTS

The development of our approach to improve health and well-being outcomes for the Kentucky Medicaid population (depicted below in **Figure I.C.24-1**) stems from our long-standing presence in the Commonwealth, as well as our broad experience serving similar Medicaid-eligible populations continuously for more than two decades through other state-based programs. Humana's Population Health Management (PHM) Program includes the following **key elements** to address the physical needs and psychosocial well-being of our Enrollees at all points along the care continuum:

- Enterprise-wide focus on population health strategies to address physical health, BH, functional, and social needs, with all plan operations held accountable **to improve health outcomes and healthy behaviors, empower Enrollees to engage in their healthcare, and address health disparities through cost-effective and tailored solutions**
- Integration of population health priorities and the **National Committee for Quality Assurance (NCQA) PHM Model** into our quality management program to **advance health equity and reduce disparities**
- **Data integration** from multiple internal/external systems and sources to provide actionable insights
- **Risk stratification** designed to optimize outcomes and maximize the impact of care and resources
- Investments in **self-management tools** and **technology-based solutions** to effectively identify and manage certain chronic conditions

- Responsive and accessible BH services, engagement in BH promotion efforts [with a focus on trauma-informed care (TIC), recovery, and resiliency], and deployment of **field-based Kentucky Medicaid BH Care Managers (CM)** to Enrollees who require BH services
- Social, economic, and environmental factors that influence health addressed as **critical gaps in care** and implementation of innovative cross-sector strategies that include **targeted, person-centered interventions** to continuously enhance Humana's comprehensive model of care
- **Humana Kentucky Medicaid Community Engagement coordinators, Community Health Workers (CHW), SDOH coordinators, and Housing specialists** dedicated to building relationships with community partners in the Commonwealth and addressing the needs of individual Enrollees
- **Value-based payment (VBP) arrangements and incentive models for providers** to support involvement in the PHM Program
- Development and maintenance of **sustainable, strategic relationships with DMS, State agencies, community-based organizations (CBO), and providers** to create scalable and financially sustainable population health solutions informed by evidence-based and national best practices

Figure I.C.24-1: Humana's Population Health Management (PHM) Program Approach



In addition to the key program elements above, Humana has invested in multiple innovations that have been incorporated into our PHM Program to support overall health and wellness goals. The list below provides examples of our PHM programs, partnerships, tools, and offerings, discussed in greater detail throughout our response to I.C.24.a.i.

Enterprise-Wide Innovation

- Humana's Bold Goal
 - *Healthy Days*
 - *Comprehensive Social Needs Screening Channel Test*
- Identification of Health Disparities
 - *Healthy Days Outcomes Stratification*
 - *Healthcare Effectiveness Data and Information Set (HEDIS) Analysis*
 - *GEOSCAPE*
- Data Integration
 - *Market Health Scorecard*
 - *Community Health Dashboard*
 - *zoom in™ SDOH Data Visualization Tool*
 - *Social Risk Index*
- Data Governance

Community Partnerships

- United Way of Kentucky
- United Community Louisville & Unite Us
- Humana Foundation in Kentucky

Care Delivery System

- Telehealth
 - *Direct-to-Consumer Telebehavioral Health*
 - *Primary Care Provider (PCP)-Facilitated Telebehavioral Health*
 - *School-based Telehealth with Norton Healthcare*

Behavioral Health

- BH Provider Partnerships
 - *The Bounce Coalition*
 - *KVC Kentucky*
 - *Project ECHO™*

Payment Innovation

- Collaboration with Community Mental Health Centers (CMHC)
 - *KARP, Inc.*

SDOH Interventions

- Food Insecurity
 - *Cooking Matters Program*
 - *Feeding Kentucky*
- Housing
 - *Eviction Prevention*
 - *Eviction Diversion*
 - *Medical Respite*
- Employment
 - *Humana's Workforce Development Program*
 - *GEDWorks™*
 - *Dress for Success – Louisville*

Enrollee Empowerment

- Behavioral Economics
 - *Go365® Program*

ENTERPRISE-WIDE INNOVATION

Bold Goal

Since our founding, transforming healthcare and impacting SDOH have been core to Humana. In 2015, our enterprise-wide population health strategy, known as Bold Goal, began with a commitment to develop programs and partnerships to improve the health and well-being of the communities we serve. We set out on this journey by selecting seven pilot communities around the country in which to drive initiatives, with the goal of applying the learnings nationwide. Currently, we have 14 Bold Goal Communities throughout the country, with planning efforts underway to expand further. **Because of Humana's deep roots in Kentucky, the city of Louisville was one of our original Bold Goal Communities**, and we are eager to expand this work outside of Louisville Metro to include additional communities in the Commonwealth. We forged working relationships with providers, nonprofit organizations, and business and government leaders to co-create solutions aimed at addressing some of today's most complex health and social problems. We focused on implementing **culturally competent initiatives** that address SDOH needs (such as food insecurity and loneliness), recognizing these issues have a significant impact on population health. To measure our progress, Humana employs the **Centers for Disease Control and Prevention (CDC) Health-Related Quality of Life (HRQOL)** measure, **Healthy Days**.

Bold Goal in Louisville

According to the **2016 Kentucky Behavioral Risk Factor Surveillance System (KyBRFS)**, Kentuckians report having experienced 4.6 days of poor mental health in the last 30 days, which is 0.8 days greater than the national average. Overall, Louisville ranks 11th out of 50 peer cities in rates of suicide. As part of our dedication to the Commonwealth to improve these rates, Humana created the Louisville Health Advisory Board (LHAB) to facilitate a collaborative approach to address community health priorities.

In 2018, the LHAB launched an Essential Needs Navigation Pilot with Family Health Centers to assess lower-income individuals for basic non-clinical health needs. The board's Behavioral Health Committee **trained more than 2,200 community volunteers in Question, Persuade, Refer (QPR), an emergency response educational program designed to help prevent suicide** by teaching warning signs of a suicide crisis, appropriate response mechanisms, and resource referrals. LHAB and Humana will continue to work on suicide prevention and other population health priorities with both provider and community partners.

Healthy Days: Healthy Days (depicted in **Figure I.C.24-2**) began as a set of survey measures developed by the CDC and its partners for use in tracking population health status and HRQOL in states and communities. In recent years, several organizations have found Healthy Days measures useful at the national level for:

- Identifying health disparities
- Tracking population trends
- Building broad coalitions around a measure of population health

To promote engagement and improve Healthy Days, Humana performs outreach calls to remind Enrollees about upcoming and overdue preventive health visits and as a tool for our health literacy campaigns. We intend to replicate the success of our **Referral Calls Program on Healthy Days**, piloted in our Florida Medicaid market. Under this program, Humana Member Services Representatives (MSR) conducted outbound calls to our entire Florida Medicaid population. If an Enrollee answered this call and reported more than 20 Unhealthy Days, our MSRs connected back with that Enrollee to educate them on available programs to improve overall health. During this campaign, **our MSRs conducted more than 44,000 calls and linked more than 30% of Enrollees** to Humana's health improvement programs. As a result of this proactive outreach, we saw an increase in PCP visits and a significant decrease in Unhealthy Days for the Enrollees we reached. Results of this program included the following:

- **Total decrease of 2.5 Unhealthy Days (from baseline)**
- **Total decrease of 2.2 physically Unhealthy Days (from baseline)**

Humana will duplicate the success of this initiative for our Kentucky Medicaid program.

Figure I.C.24-2: CDC Healthy Days Metric



Comprehensive Social Needs Screening Channel Test: SDOH needs are major drivers of health outcomes and healthcare costs. However, Humana has limited information about the individual social needs of Enrollees in our Florida Medicaid market. To better serve this population, we sought to obtain more information and asked

Enrollees ages 18 and older to complete **The Accountable Health Communities Health-Related Social Needs Screening Tool, developed by the Center for Medicare and Medicaid Innovation (CMMI)**. In this test, we are surveying approximately 100,000 Medicaid Enrollees for a comprehensive set of social impacts, which will help us understand the holistic needs of our Enrollees and how these social needs (e.g., living situation, transportation barriers, and relationships with family and friends) may co-occur, compound, and influence health outcomes, utilization, and health-related quality of life. These person-level datasets will greatly enhance Humana’s social risk modeling capabilities.

We plan to continue Healthy Days outbound calls to Humana Medicaid Enrollees, including our Kentucky Medicaid population. Humana will leverage a multi-channel communication strategy with Intelligent Voice Response/Voice Activated Typewriter (IVR/VAT) calls, emails, and text messages to screen Enrollees for social needs. With this, we will gain a better understanding of Enrollee preferences for outreach communications and inform SDOH data collection going forward.

Identification of Health Disparities

Humana deploys innovative tools and approaches to stratify Enrollees within health disparity variables to identify sub-populations:

- **Healthy Days Outcomes Stratification:** Humana analyzes Healthy Days data by lines of business, markets, chronic conditions, SDOH, and many demographic factors, including age, gender, race, and ethnicity. This allows for a deeper understanding of these populations and tailored interventions to address specific needs.
- **Humana’s HEDIS Analysis:** Our HEDIS data analytics team identifies trends in HEDIS performance by race, ethnicity, gender, language spoken, and geographic location that may indicate disparities in health outcomes.
- **GEOSCAPE:** We use GEOSCAPE’s tool to view ethnicity, country of origin, and language data at the zip code level.

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Every community we serve is unique. Because of this, there is no one-size-fits-all answer to improving population health. The CDC Healthy Days assessment tool allows us the flexibility we need to pinpoint where and when health happens in each community, to measure health outcomes, and to create proactive interventions.
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– Dr. Andrew Renda, MD, MPH
Associate Vice President,
Humana’s Bold Goal
Population Health Strategy

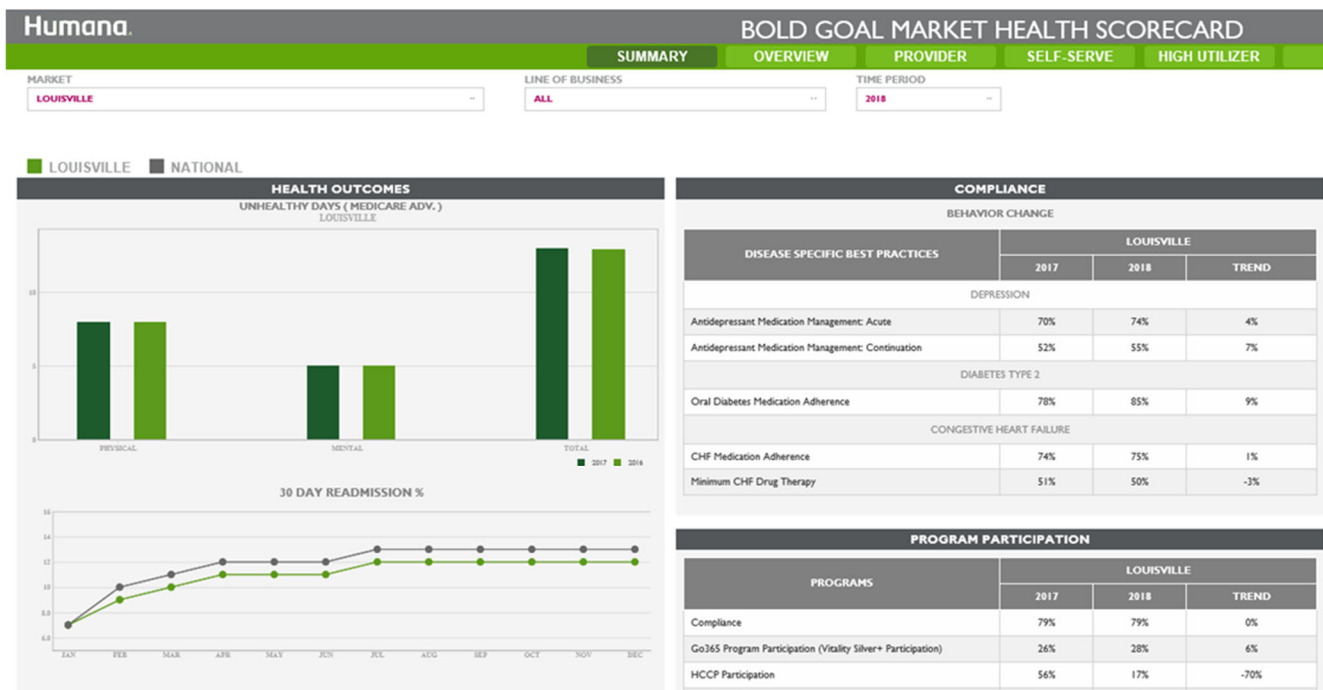
DATA INTEGRATION

Market Health Scorecard

Drawing from multiple sources including claims data, Humana’s Market Health Scorecard summarizes more than 100 key health, clinical, and financial business performance metrics to measure the overall health of a community and identify opportunities for population health improvement. This tool is a highly interactive data visualization of our Medicaid, Medicare, and Commercial Enrollees and can be filtered by market, physician group, and condition. We will use the Market Health Scorecard to help identify key performance indicators that correlate with Healthy Days and align initiatives accordingly.



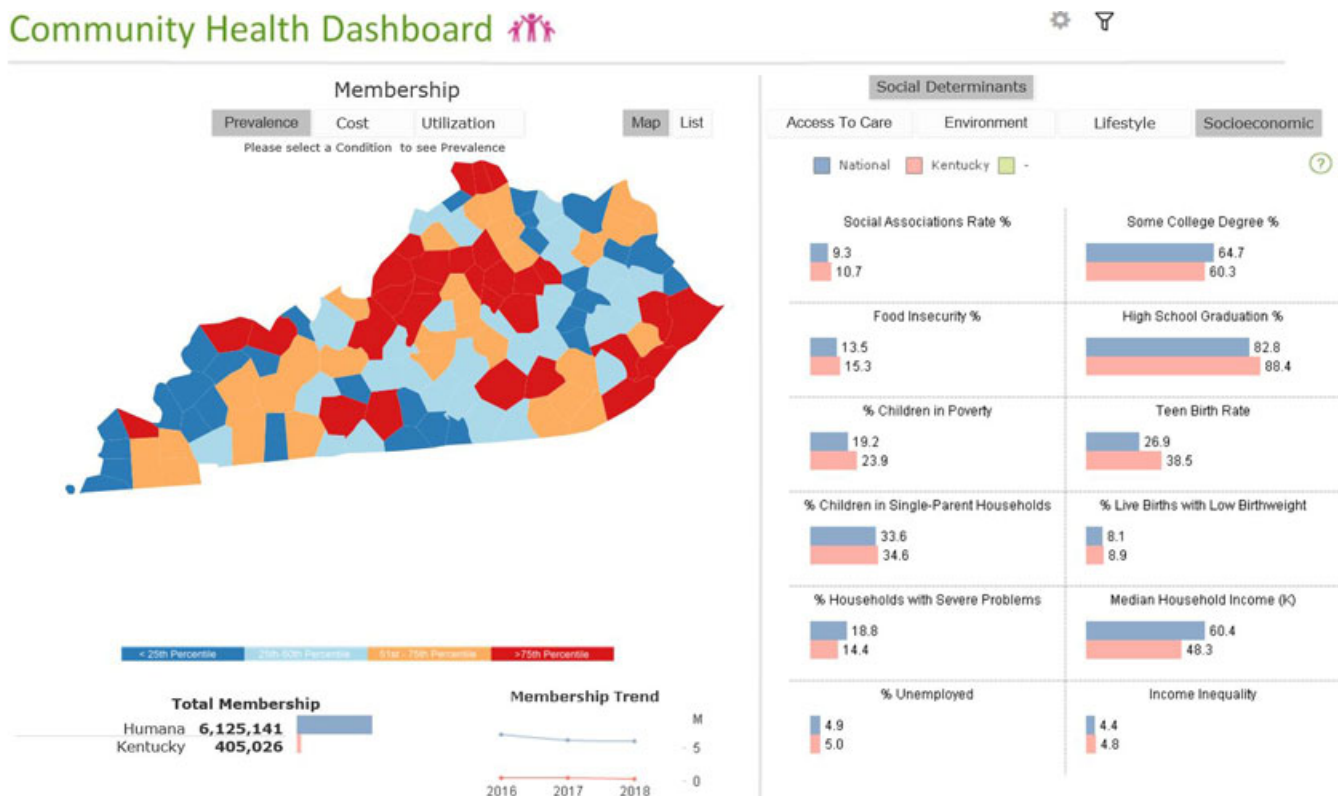
Figure I.C.24-3: Humana's Market Health Scorecard



Community Health Dashboard

We use the trends, insights, and population benchmarks from our Community Health Dashboard (Figure I.C.24-4), which combines medical claims data with Robert Wood Johnson Foundation County Health Rankings to devise population health strategies and identify pilot communities in which to test them.

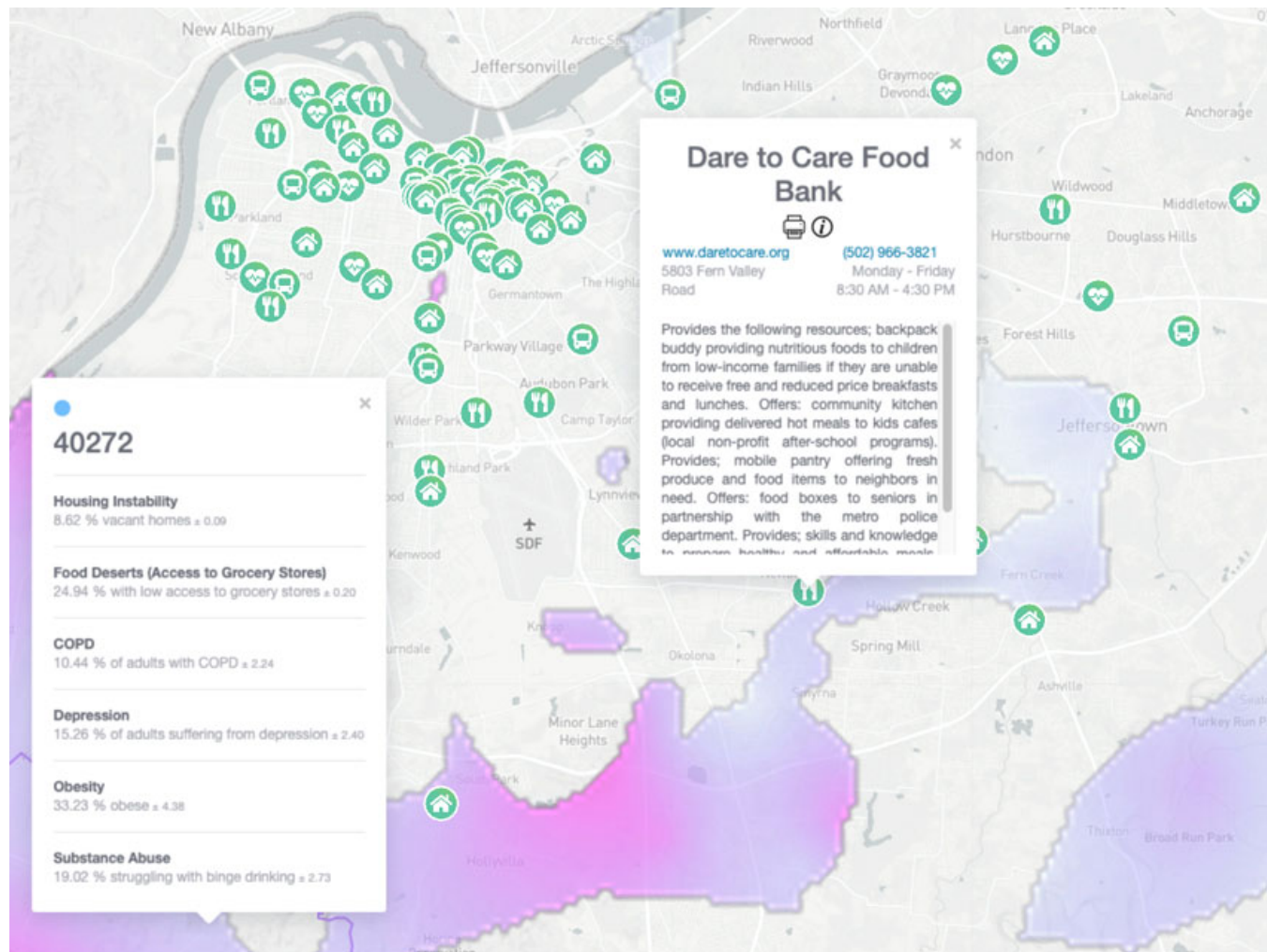
Figure I.C.24-4: Humana's Community Health Dashboard



zoom in™ SDOH Data Visualization Tool

zoom in™ (shown in **Figure I.C.24-5**) is an innovative SDOH mapping tool created by Humana's Bold Goal team, in collaboration with our Enterprise Data and Analytics team. Pulling together dozens of indicators from national public data sources, zoom in™ offers advanced heat map functions with select curated views, as well as options for the user to layer in additional SDOH indicators to generate more complex composite heat maps at a neighborhood level. Users may also search by address to view summary data points relative to SDOH risk. The tool also features a Community Resource Directory (CRD), providing key assets nearest to addresses, including community centers and food pantries. Importantly, **zoom in™ is a free, public, web-based tool that can be used by providers and CBOs, as well as Humana teams and associates.**

Figure I.C.24-5 Humana's zoom in™ SDOH Data Visualization Tool



Social Risk Index

Research from the Virginia Commonwealth University Center on Society and Health and the Robert Wood Johnson Foundation has demonstrated that neighborhoods may be a key indicator of life expectancy. Factors influencing this are zip code-level disparities in education and income, housing stability, access to healthy foods, access to safe recreation, and others. Identification of neighborhoods with higher risk levels can alert us to emerging risk or hidden risk within our Kentucky membership.

Humana is developing a **social risk index** derived from SDOH data, clinical outcomes data, environmental and geographic-level data, and consumer data. The index will be validated using positive screening data for SDOH needs, along with health utilization and outcomes. When applied to the Enrollee population, **the social risk**

index will identify communities and neighborhoods that (as a whole) present with SDOH needs. For example, a higher social risk score for a certain community with a high prevalence of diabetes may indicate an area with limited access to nutritious foods, placing the residents at risk for poorly controlled blood sugar and associated complications. With findings such as these, this innovative tool will allow Humana to intervene accordingly to support the overall goals of improving health outcomes for the population and empowering individuals to improve their health and engage in healthcare. Our interventions include (but are not limited to) referrals to care management and support from our Kentucky Medicaid CHWs, SDOH coordinators, and Housing specialists, in addition to the partnership and program opportunities described below.

Data Governance

Humana's corporate Digital Health and Analytics team will use SDOH as an initial use case for its data lake platform. A data lake is a storage repository that has a vast amount of raw data. SDOH data may come from a number of sources and in a variety of formats (e.g., community- or Enrollee-level, structured or unstructured, and internally or externally collected). With Humana serving as data stewards, these datasets will be located, certified for quality, and ingested into the data lake. Fit-for-purpose data products will then be available for any number of use cases to support business operations, analytics, and product development. This rigorous data governance process will not only ensure the integrity of SDOH data, but will also ensure that data can be confidently and consistently applied across Humana operations to improve the care we provide to Enrollees.

COMMUNITY PARTNERSHIPS

United Way of Kentucky

Humana is committed to working with **United Way of Kentucky** to broaden coverage of 2-1-1 across the Commonwealth. The Kentucky 2-1-1 CRD is powered by United Way across the Commonwealth but does not have contact centers and coverage in all counties. Through Humana's new partnership with the United Way of Kentucky, we are helping fund and deliver 2-1-1 services to the entire Commonwealth, with an expectation of addressing efficiency and standardization of user experience as we move forward.



United Community Louisville

United Community Louisville is a community-wide, community-driven, agency-linkage technology platform system in which individuals are matched with appropriate community services based on their unique needs across the health, education, and social service sectors and managed to closure. CBOs are connected to services via the platform, which facilitates referrals and information sharing, including "closing the loop" on referrals by sharing information when Enrollees access a community agency service. **Unite Us** [the vendor selected by Metro United Way, the Louisville Health Advisory Board (LHAB), and other community partners for the **United Community Louisville pilot**] operates a proven cross-sector health and social care coordination platform in 40 communities nationwide and is currently hiring locally-based staff to support the program.

The goals of Humana's investment in the United Community Louisville pilot include:

- **Development of a connected, collaborative, community-wide system to coordinate care and services** across multiple sectors to address SDOH needs, promote education, and offer real-time tracking and reporting
- **Measurably improve health, education, and well-being outcomes** by coordinating the delivery of health and social services among children, individuals, and families with complex needs

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We thank Humana for their support for United Way's data-driven initiatives and applaud Humana for their willingness to work with us to address gaps in how human services are delivered to improve individual and family outcomes across critical social determinants of health.
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— Kevin Middleton, President,
United Way of Kentucky

- **Creating a “no wrong door” system** whereby individuals are channeled to appropriate services based on their unique needs and preferences across the health, education, and social service sectors and tracking outcomes after service referrals

Our investment includes licenses that will allow our CHWs and CMs to access the referral platform fed by the Metro United Way 2-1-1 CRD, make community-based referrals, and ensure Enrollee access to state-based services.

Humana Foundation in Kentucky

In addition to our long-standing partnerships and programmatic involvement with CBOs, the Humana Foundation [a 501(c)(3) entity with a governing and grant-making body separate from Humana market leadership] has contributed nearly **\$30 million to Kentucky non-profits and organizations statewide since 2013**. During this time, the Humana Foundation made more than \$2.6 million in grants to Metro United Way, with a focus on improving health equity and financial empowerment for low-to-moderate income individuals and families. Organizations that have received grants directly support the Commonwealth’s population include (but are not limited to):

- Big Brothers Big Sisters of Kentuckiana
- Boys and Girls Club of Kentuckiana
- Bridgehaven
- CASA of the River Region
- Dare to Care
- Down Syndrome of Louisville
- Health Equity Fund
- Louisville Urban League
- YMCA of Greater Louisville

In 2020, the Humana Foundation is granting \$2.2 million to Kentucky non-profit organizations through the 2020 Community Partners Program. Grants will be awarded to organizations that propose collaborations across sectors to positively affect issues impacting health equity, diversity and inclusion, and initiatives aimed to reduce barriers to care and services. Awardees must demonstrate data-based evidence of past success, development of sustainable solutions, and a focus on broader community impacts. Through this program, Humana’s goal is to bolster the work of our existing community partners and engage in new partnerships with organizations statewide.

CARE DELIVERY SYSTEM

Telehealth

Direct-to-Consumer Telebehavioral Health: **Humana has partnered with MDLIVE to increase access to direct-to-consumer telebehavioral health services.** Our Enrollees can use the MDLIVE platform to receive a psychiatric diagnostic evaluation, individual and family psychotherapy sessions (30 to 60 minutes), and ongoing BH evaluation and management sessions (15 to 40 minutes) via phone or video. A psychiatrist or Masters- or PhD-level therapist will provide these services. In addition to educating Enrollees about MDLIVE through our traditional Enrollee education channels (including our website, Enrollee Handbook, and Enrollee newsletters), we will disseminate information on MDLIVE’s telebehavioral health offerings to our Kentucky Medicaid network PCPs to encourage referrals after a positive screening for depression or other BH need. In addition, our CMs will routinely educate Enrollees on MDLIVE’s virtual urgent care and telebehavioral health capabilities and offer to directly enroll them in MDLIVE to enable access to services when needed. We have found that Enrollees are more likely to join MDLIVE if their CM offers to enroll them directly.



PCP-Facilitated Telebehavioral Health: Humana is committed to furthering the integration of care by improving the availability of BH services within PCP offices. In addition to the mechanisms described in our response to

Section I.C.23.c of the Request for Proposal (RFP), Humana is working with **Arcadian Telepsychiatry** to deliver BH services within PCP offices. Under this system, PCPs can directly arrange BH services for their patients who screen positive for a BH need, allowing those Enrollees to receive BH services (including the prescribing of controlled medications) right in their PCP's office. This arrangement will particularly benefit those residing in rural or underserved areas who may otherwise face lengthy trips to receive BH services or who have no access at all.

Humana has contracted with **SUN Behavioral Health**, located in Northern Kentucky, for telebehavioral health services, including family therapy, follow-up visits after hospitalization, and outpatient therapy. We are in active conversations to establish a value-based contract with SUN Behavioral Health for follow-up after hospitalization.

School-based Telehealth with Norton Healthcare: 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, conjunctivitis, and upper respiratory infections, among other conditions. These innovative programs improve access to care and perhaps more importantly, **offer convenient access to care**. Without school-based telehealth programs, children often need their parents to take time off of work for doctor visits. For low-income families, skipping a shift at work to visit a provider can have serious consequences, and delaying treatment leads to preventable emergency department (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 telemedicine program in Jefferson County Public Schools**. Humana will sponsor the telemedicine technology Norton Healthcare uses to remotely examine the student with the assistance of the school nurse. This support allows 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. Humana and Norton Healthcare see this as an opportunity to keep children in school, healthy, and learning.

BEHAVIORAL HEALTH

BH Provider Partnerships

The Bounce Coalition: Humana has entered into a partnership with the Bounce Coalition, working with schools to address the root causes of poor health in the most vulnerable children. We will implement the CDC's "Whole School, Whole Community, Whole Child" model, a student-centered, 10-component framework designed to address health in schools and connect better health with academic achievement. We will collaborate with teachers, parents, and others who interact with children and families to **recognize the impact of Adverse Childhood Experiences (ACE) and equip children with resiliency-building skills and coping mechanisms for dealing with trauma**. Through this collaboration, Bounce will train our MSRs, CMs, and CHWs on ACEs and TIC.



KVC Kentucky: Providing an array of BH (including SUD) and child welfare services, **KVC Kentucky** targets the significant problems that families face in our society. Serving more than 12,000 children and families each year, they provide in-home BH and SUD treatment, family preservation and reunification, and foster care services. Committed to strengthening and supporting the well-being and vitality of Kentucky's children, families, and communities, this partnership will deliver high-quality, impactful services designed to empower our Enrollees by building on their unique strengths. Humana will collaborate with KVC Kentucky to identify children at risk of out-of-home placement and provide them with:

- Appropriate services and interventions to keep the child in their home, including offering parenting classes and appropriate therapies to parents

We will work with **KVC Kentucky** to implement a **value-based program** that incentivizes all parties, across the spectrum of providers offering preventive services, to work together across the continuum of care.

- Work to complete appropriate assessments and share the results of these assessments with Humana

Project ECHO™: 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 by fostering communication with and learning from one another through provider-to-provider consultations and educational forums. Humana is exploring opportunities to partner with leading academic institutions to launch **Project ECHO™** programs focused on critical areas of educational need, including BH. 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 appropriately and effectively care for complex patients 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.

PAYMENT INNOVATION

Collaboration with Community Mental Health Centers

We intend to partner with KARP, Inc. regarding a proposal to **pay a care coordination Per Member Per Month (PMPM) fee to its member CMHCs**. If successful, we will look to expand this model to our other network BH providers. This agreement, based on a similar existing agreement between Humana and the Kentucky Primary Care Association (KPCA) to pay care coordination fees to member Federally Qualified Health Centers (FQHC), will give our BH providers the additional resources needed to support administration and care coordination tasks, including discharge planning for Enrollees with serious mental illness (SMI).



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 this bundled payment to lessen this burden and promote delivery of High Fidelity Wraparound supports to our child and adolescent Enrollees with BH needs. These wraparound services will be critical to the Commonwealth's adoption of the Family First Prevention Services Act, which will support families and promote permanency.

SDOH INTERVENTIONS

Food Insecurity

Food insecurity is a significant and pressing need among many of our Enrollees, with particularly high rates experienced in Region 9 of the Commonwealth.¹ We are committed to a series of partnerships that strengthen our ability to address food insecurity within our Kentucky Medicaid population, empowering our Enrollees to improve their health and engage in their well-being journey.



- **Cooking Matters Program:** In partnership with Share our Strength and Feeding Kentucky, we will work with community partners to teach families basic cooking skills, how to budget, as well as how to utilize **Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children (WIC) benefits**.
- **Feeding Kentucky:** We are exploring a pilot partnership to **distribute medically tailored food boxes via FQHCs**, working through the Kentucky Health Center Network. Providers receive training on screening for food insecurity as part of their broader screening efforts. Eligible patients are then able to receive prescriptions for a food box filled with healthy food items.

Housing

Eviction Prevention: Key to our strategy in serving our at-risk Enrollees is continuing to take steps with our community partners to prevent evictions in the first place. We will support the efforts underway at both the **Volunteers of America (VOA)** and **Legal Aid Society** to develop constructive relationships with developers and landlords and provide education and an avenue for early identification of at-



¹ <https://map.feedingamerica.org/county/2017/overall/kentucky>

risk Enrollees. At the same time, using the results of our Health Risk Assessment (HRA) and the **Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)**, we can target services and supports to promote financial literacy and connect Enrollees to the Humana Workforce Development Program.

Eviction Diversion: In cases where eviction cannot be prevented, partnerships with VOA Mid-States, Inc., Legal Aid Society, and other local community organizations will enable us to:

- Understand the underlying risks and issues that may lead or have led someone to potential eviction
- Develop a viable action plan with the Enrollee
- Negotiate with the housing authority and/or landlord on behalf of Enrollee
- Provide legal aid and support to individuals in need

Upon identification of housing insecurity risks, referrals will be made to VOA CMs. VOA has an existing relationship with the local Housing Authority in Louisville, as well as local landlords and housing developments, and a process in place to receive referrals directly from the Housing Authority for Enrollees at risk. Humana and VOA will work together to establish protocols for identifying healthcare needs that may be related to housing insecurity and ensure appropriate referral to, and coordination with, care management and health plan resources to provide support for critical health needs.

Medical Respite: **Medical respite** is designed to address the acute and post-acute medical needs of persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to remain in a hospital. Research has shown medical respite programs to be effective in reducing subsequent ED visits and inpatient admissions and thus reducing hospital costs. Dedicated respite beds will be made available in VOA facilities equipped to house Enrollees in need, with tailored attention to the unique experiences of both individuals and families. Access to the medical respite bed and the critical wraparound services will be covered for a period of time that is deemed medically necessary. During this time, Humana CMs and VOA site managers will work together with Enrollees on next steps toward rapid rehousing or more permanent supports.

Employment

Humana's Workforce Development Program: Humana recognizes that the health of our Enrollees is dependent upon their well-being and stability. Our voluntary, holistic workforce development program is designed to help Enrollees find dignified, stable work that affords increased self-sufficiency for themselves and their families. The **Humana Workforce Development Program** will provide up to 12 months of assistance to support each participant in planning for the future (e.g., education, training, financial counseling) and engaging in and maintaining meaningful work (e.g., job support and retention coaching). We will seek to build access to a network of CBOs with expertise in providing these services by rewarding those organizations who successfully place and stabilize employees. Additionally, we will connect Enrollees to resources across the community to address any unmet needs that present barriers to finding and retaining employment.



GED Support for Humana Enrollees: Humana will offer reimbursement for tools that empower our Enrollees to get their GED. Humana Enrollees will have access to **GEDWorks™**, a program that includes the assignment of a bilingual advisor, access to guidance and study materials to prep for the tests, unlimited use of practice tests, and a test pass guarantee. The test pass guarantee ensures that Enrollees can take the test multiple times (at no cost to the Enrollee) until they are able to pass. With the exception of the actual GED test, all other components are offered virtually, allowing maximum flexibility for our Enrollees to meet their goals.

Dress for Success – Louisville: To support our female Enrollees seeking employment, we are building a direct referral process with **Dress for Success – Louisville**, which serves job-seeking women through career mentoring, financial education, and the provision of professional career attire in the greater Louisville area.

ENROLLEE EMPOWERMENT

Behavioral Economics

Humana promotes Enrollee engagement and empowerment by incenting behavior change and self-management. For our Kentucky Medicaid program, our Enrollee incentives will be deployed through **Go365®, Humana's proprietary personalized wellness program**. Go365® is designed to help Enrollees make healthier decisions and guide them on their personal well-being journey. Go365® incorporates practices of behavioral economics to motivate Enrollees to complete healthy activities. To encourage engagement in their own healthcare, promote prevention activities, improve outcomes, and address SDOH needs, Go365® rewards Enrollees for PCP visits and HRA completion, as well as 10 other health-related activities. Kentucky Medicaid Enrollees can receive gift cards through mail or real-time via email to places like Walmart, Shell, and Amazon.com.



Go365 Enrollee Success over a Three-Year Period

- 6% lower healthcare costs in Year 1
- 10.1% cost reduction by Year 3
- 56% fewer ED visits
- 37% fewer hospital visits

Humana will incentivize Enrollees for the following behaviors:

- HRA completion
- Prenatal and postpartum care visits
- Well-child visits during the first 18 months of life
- Annual preventive care visit
- Completing education modules on when to access the ED (appropriate level of care training)
- Pediatric dental visits
- Diabetic screenings
- Mammograms (female Enrollees ages 50 to 64)
- Cervical cancer screenings (female Enrollees ages 24 to 64)

Additionally, we will use Go365® to promote:

- Completion of the HRA: Enrollees can complete the HRA directly in their Go365® smartphone application.
- Education & Community Engagement: Go365® will promote Medicaid-specific wellness initiatives to maximize Medicaid Enrollee participation. The program includes educational materials and webinars all on one platform for instant Enrollee access, encouraging participation in community events such as low-impact workouts and nutrition classes at a local Humana Neighborhood Location or hosted elsewhere in the community.
- Quality: Go365® aligns activities and incentives to support Medicaid quality initiatives focused on preventive care and adherence. Enrollees receive gap-in-care alerts, as well as health promotion materials.

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If the Contractor holds NCQA PHM Accreditation, describe the Contractor's implementation of related models, lessons learned, challenges and successes.

Humana's PHM Program aligns with NCQA's PHM component requirements as demonstrated by Humana receiving full NCQA Medicaid Health Plan accreditation in November 2019. As a part of that accreditation survey, NCQA reviewed all aspects of our Kentucky operating model, including PHM components and requirements for accreditation.



IMPLEMENTATION OF RELATED MODELS

Humana currently employs a population health model that encompasses care management, data integration, population assessments, Enrollee stratification, and targeted interventions based on priority populations, as well as quality measurement and enhanced provider support models. We have implemented population health-based models in both our Kentucky and Florida Medicaid Managed Care (MMC) programs. In both Kentucky and Florida, our PHM programs support our Enrollees at all stages of health, from health promotion and wellness, to

complex and intensive care management. We emphasize management of chronic conditions, empowering Enrollees to take an active role in their healthcare and self-management. Integrating physical health, BH, and SDOH needs allows us to capture a holistic view of our membership.

Our integrated model of care delivery incorporates person-centered care management, combined with a multi-pronged approach to improving the health and well-being of populations through elements such as SDOH (i.e., housing and food insecurity), innovative provider payment models, sophisticated data analytic capabilities, and robust quality measurement.

Table I.C.24-1 below illustrates how we have integrated NCQA PHM components into our PHM model.

Table I.C.24-1: NCQA PHM Components Integrated into Humana's PHM Model

PHM Standard	Humana's Corresponding Population Health Component
PHM Strategy	<ul style="list-style-type: none"> Fully integrated clinical platform, Clinical Guidance eXchange (CGX), allows for a whole person view of medical, behavioral, and social needs/services Electronic Health Record (EHR) data flows to and from providers to facilitate real-time information exchange Enrollee care profile, service authorizations, gap-in-care alerts housed within CGX
Population Identification	<ul style="list-style-type: none"> HRA attempts for 100% of the population, including identification of SDOH needs Enrollee Needs Assessments to screen for additional or more complex medical, BH, or social needs Risk identification and stratification using Humana's proprietary predictive models <ul style="list-style-type: none"> Medicaid Severity Score Predictive Model ED Predictive Model Readmission Predictive Model Opioid Predictive Model Social Risk Index Stratification based on factors such as age, race/ethnicity, sexual orientation, religion, primary language, disability status, and income level to identify potential health disparities Identification of sub-populations experiencing a disparate level of needs, including housing, food insecurity, physical safety, and transportation
Delivery System Supports	<ul style="list-style-type: none"> Value-based provider model that supports our providers in high-quality care delivery Quality Improvement Advisors (QIA) conducting face-to-face onsite visits with providers to discuss utilization metrics, quality performance, and practice transformation Data-sharing capabilities with our providers through EHRs and systems interoperability
Wellness and Prevention	<ul style="list-style-type: none"> Targeted Enrollee interventions developed and implemented based on acuity levels: <ul style="list-style-type: none"> Health Promotion and Wellness Management of Chronic Conditions Intensive Care Management Complex Care Management Bold Goal work in Kentucky to promote overall health and well-being of the population
Complex Case Management	<ul style="list-style-type: none"> Defined set of targeted interventions for high-risk Enrollees <ul style="list-style-type: none"> Enrollees with Special Health Care Needs (ESHCN) Integrated care delivery for Enrollees with multiple co-morbidities (physical health, BH, and SDOH needs)
Population Health	<ul style="list-style-type: none"> NCQA-accredited health plan

Table I.C.24-1: NCQA PHM Components Integrated into Humana’s PHM Model

PHM Standard	Humana’s Corresponding Population Health Component
Management Impact	<ul style="list-style-type: none"> • Monitor, track, and trend quality measures: HEDIS, 3M Potentially Preventable Events (PPE), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Commonwealth-defined • Rapid cycle improvement processes for continuous quality improvement • Measure quality outcomes at the population and individual level
Delegation of PHM	<ul style="list-style-type: none"> • Collaboration with delegated entities (i.e., dental and vision partners) to further our PHM goals through the provision of Covered Services

LESSONS LEARNED

Integrated Care Delivery: We have found, through our experience in working with and managing vulnerable populations including those with special health care needs, a successful PHM Program results from our different operational components working seamlessly to create a truly integrated model. Based on this experience, our integrated model combines predictive modeling, Enrollee outreach, community engagement, provider partnerships, care management, and SDOH services and supports to form a holistic approach to care delivery.

Culturally Competent Service Delivery: We have learned the importance of culturally competent service delivery in improving the health of our Enrollees. Cultural competency is an integral component of our culture at Humana, requiring associates who serve Medicaid Enrollees to complete supplementary training tailored to this population, including topics such as Health Literacy and Numeracy, Cross-Cultural Negotiation, and Understanding Seniors and People with Disabilities. We hire staff locally from the communities they serve. For example, we currently employ locally embedded CHWs as part of our PHM Program model in the Commonwealth.

Community-based Care Coordination and Sustainable Solutions at the Local Level: We have learned to co-create sustainable solutions at the local level instead of supplanting and duplicating services. By working within an existing locally-based care management framework and enhancing and supplementing services in place, we can leverage the invaluable experience of those working in the communities we serve. Our Bold Goal work has driven our experience in working with Enrollees and organizations across our communities. **Because of Humana’s deep roots in Kentucky, the city of Louisville was one of our original Bold Goal Communities**, and our efforts have since expanded across the Commonwealth. We forged working relationships with providers, nonprofit organizations, and business and government leaders to co-create solutions aimed at addressing some of today’s most complex health and social problems. We focused on implementing **culturally competent initiatives** that address SDOH needs (such as food insecurity and loneliness), recognizing these issues have a significant impact on population health.

Data Analytics and Data Sharing Capabilities: The ability to effectively capture, analyze, and disseminate data is also a key component of a successful PHM Program model. By applying learnings from continuous process improvement evaluations, we have developed a robust set of analytics tools that enable us to monitor outcomes and trends within our Enrollee populations and share that information internally and with network providers. These analytics tools are included in **Table I.C.24-2** below.

Table I.C.24-2: NCQA PHM Analytics Tools

Analytic Tool	Description
Population Insights Compass (Compass)	Compass draws upon CareHub data to provide an integrated view of gaps in care, services, and needs across the provider's patient panel into actionable reports. Continuous monitoring and reporting at the state, regional, and physician level enables providers to easily identify patients and/or groups requiring additional support.
Inpatient Census Report	Daily detailed account of acute/sub-acute inpatient facility admission cases
3M PPEs Report	Identifies admissions, readmissions, facility-based complications, ED visits, and ancillary services that likely could have been prevented
Inpatient Clinical Dashboard	Weekly reporting of key operational metrics, such as time from receipt of authorization to nurse receipt, time for clinical decisions, discharge plan documentation, Enrollees contacted for post-discharge follow up, clinical program reach, and engagement rate
Early Indicator Report (EIR)	Monthly reporting of key utilization metrics such as: admits/1,000 by utilization type [Acute, Skilled Nursing Facility (SNF), Rehab, Long Term Acute Care Hospital (LTACH)], inpatient days/1,000, length of service by type, ED visits/1,000, etc. Dashboard format allows user drilldown for analysis by demographics such as geographic region, plan type, and age of user
High Utilizer Report	Monthly report to drill down into individual Enrollees with high utilization by service type (e.g., ED, inpatient care)
Provider Utilization Profiling	Quarterly provider-level report of claims and encounter data to analyze under and overutilization and to provide peer-to-peer analysis
Predictive Model Reporting	<ul style="list-style-type: none"> • Medicaid Severity Score Predictive Model (updated monthly) to inform Enrollee stratification • Inpatient and Readmission Predictive Models (updated daily from admission to discharge) are integrated into our clinical platform, CGX, to trigger referrals for clinical programs • ED Predictive Model scores (available by report each month) are integrated into CGX • Opioid Predictive Model to enhance efforts to identify high-risk Enrollees
Readmissions by Provider	Monthly tracking of 14- and 30-day readmission rate for acute admissions and provider visit within 14 days of discharge date
High-Cost Prescription Report	Report identifies Enrollees who have 10 or more unique drugs that average more than \$250 per prescription

SUCSESSES AND CHALLENGES

Successes

Expanding Access to Preventive Care: To improve access to care and accommodate Medicaid Enrollees' schedules, **Humana will offer an Extended Hours Bonus.**

We successfully **reduced ED visits by more than 12% in 2018** in Kentucky as a result of extended office hours.

Improving Well-Child Visits in the First Six Years of Life: In 2016, only 58.9% of our Kentucky Enrollees ages three to six received the recommended one or more well-child visit(s). The lack of care indicated by these rates was due to a combination of barriers including (but not limited to) a lack of knowledge by caregivers of the

importance of regular well-child visits, difficulties they face accessing PCP care for their child, and the PCP's lack of adherence to best practices. Conversely, the rates also highlighted an opportunity for us to assist and engage Enrollees and providers in overcoming these barriers so Enrollees can receive the care they need and to which they are entitled. Associated interventions included:

- Provider education via newsletters
- Enrollee education via newsletters, booklets, calendars
- Team-based outreach calls and community events for Enrollees and their caregivers
- Enhanced care management

These interventions yielded a 6.3% increase in the HEDIS W34 rate (well-child visits three to six years of life) from 2016 to 2018.

Expanding Access to Urgent Care and After-Hours Care: In October 2017, Humana launched an urgent care strategy that included contracting with additional urgent care centers to expand access in Florida. We saw an immediate two percent shift from ED to urgent care from 2016(Q4) and 2017(Q3) to 2017(Q4) and 2018(Q3). Humana is continuing this strategy by further expanding access to these centers and launching campaigns to communicate this to both PCPs and Enrollees. We also implemented a provider after-hours initiative to increase the number of network PCPs and BH providers offering after-hours appointments.

We expect our providers to educate their Enrollees on the additional hours and days they will be open and will educate Enrollees on when it is appropriate to contact their PCP before going to the ED, if they are unsure if they need to go to the ED. **We have reduced ED visits by more than 12% in 2018 in Florida as a result of extended office hours.**

Improving outcomes for high-risk infants: In our Florida Medicaid program, through our MomsFirst prenatal and postpartum case management and specialized Neonatal Abstinence Syndrome (NAS) management programs, we saw significant reduction in zero to two months cohorts' acute and Neonatal Intensive Care Units (NICU) admissions from 2017 to 2018. In our Temporary Assistance for Needy Families (TANF) zero to two months population, **admissions per thousand decreased by 6.8 percent** (682.0 to 635.6) and **average length of stay decreased by 4.2 percent** (12.36 days to 11.83 days). In our Supplemental Security Income (SSI) zero to two months population, **admissions per thousand decreased by 23.4 percent** (1,969.5 to 1,508.6) and **average length of stay decreased by 17.6 percent** (52.58 days to 43.33 days).

Reducing Inpatient Admissions: In our Florida Medicaid program, we implemented a robust front-end review process to review ED admissions prior to approving a subsequent inpatient stay. If the Enrollee meets the standards for an observation level of care, we approve the lower level of care, rather than the inpatient stay. **As a result, we saw a 13.9 percent increase in the observation rate and a 7.1 percent decrease in inpatient admissions in our Florida Medicaid plan from 2017 to 2018.**

Enrollee Experience with Care Management: We conducted a survey to assess satisfaction among our Enrollees who participated in the Humana Florida Medicaid care management program from 2018 to 2019. After participating in our care management programs, **95% of Enrollees said they were more prepared to manage their own health.**

Challenges

Identifying and Addressing Social-Related Needs: SDOH needs (such as food insecurity, homelessness, and transportation access) have a significant impact on population health. As we strive to better address these types of needs within our Kentucky Medicaid population, accurately identifying the needs and types of services necessary is a challenge. We have mitigated this challenge by:

- Administering a social needs assessment (a supplemental survey to the HRA and Enrollee Needs Assessment) for Enrollees with identified SDOH needs, conducted as needed
- Exploring ways to educate and incentivize our providers for SDOH screenings

- Including an SDOH coordinator from our Comprehensive Care Support (CCS) team to help connect Enrollees with community resources
- Utilizing CHWs to meet with Enrollees in the community to form a personal connection and facilitate conversations around potential SDOH needs

Behavioral Health Integration: Integration of physical and BH is essential to successfully manage the needs of our Enrollees. Humana operates a fully integrated clinical model, managing both the physical and behavioral health of our Enrollees. Through the development of this internal model, we navigated the following challenges:

- Ensuring CM distribution across both physical health and BH specialties meets Enrollee needs.
- Tailoring CM training and education efforts, taking into account each specialty and the cross-training needed to manage a comprehensive model. To navigate this, we provide BH first aid educational materials to our nurse CMs. Likewise, we provide chronic condition education materials to our BH CMs.
- Highly complex Enrollees with comorbid physical health and BH diagnoses may necessitate higher staffing. We continue to reassess our staffing models and ratios to maintain our commitment to quality services and improved outcomes.

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Plan to ensure high levels of Enrollee participation across all priority populations and conditions, including innovative methods for contacting and engaging Enrollees to initiate completion of Health Risk Assessments and Enrollee Needs Assessments.

Early identification of physical health, BH, and SDOH risks within our membership is a core element of our population health strategy, and Humana is committed to advancing the Department's goal of improving HRA completion rates and timeliness. Below, we outline our processes for HRAs and Enrollee Needs Assessments, and our strategies to ensure high levels of Enrollee participation across all priority populations and conditions.

From January 1 to January 29, 2020, Humana sent Enrollee Welcome Kits to all Kentucky Medicaid Enrollees. Since then, we have received **6,394 completed HRAs**.

HEALTH RISK ASSESSMENT

Initial Engagement

Humana's HRA process is designed to meet and exceed the Department's contractual requirements and timelines, as outlined in Section 34.3 Population Health Management Program Tools of the Draft Medicaid Contract. At all touchpoints with our Enrollees, we make every effort to educate them on the purpose of the HRA and about the services and supports available through our PHM Program. To maximize completion of the HRA within 30 days, **we will make a minimum of six HRA completion attempts for all Enrollees, exceeding state requirements**. We will take the following sequential steps to reach our Kentucky Medicaid Enrollees:

1. **Welcome Kit via mail**: Upon enrollment, all new Enrollees will receive a copy of the HRA in their **Humana Kentucky Medicaid Welcome Kit**, along with a pre-addressed envelope with return postage. The Welcome Kit also includes a welcome letter listing next steps the Enrollee can take to better manage their health, the Enrollee Handbook, a description of their value-added services, and a consent for release of medical information form. We will also notify the Enrollee of their CM's name, if applicable.
2. **Three outbound calls**: We will make three attempts by telephone within the first 30 days of enrollment on different days of the week and at different times of the day.
3. **Health Insurance Portability and Accountability Act (HIPAA)-compliant postcard**: We will mail one, HIPAA-complaint postcard asking the Enrollee to call our Member Services Call Center for assistance. This will be sent after a third unsuccessful phone attempt.
4. **Fourth outbound call**: If the above outreach methods are not successful, we will make one additional attempt by telephone within the first 30 days of enrollment.

To increase the likelihood that our initial telephone outreach is successful, we work with Revel Health, LLC, to enhance the data received on the 834 enrollment file with data from commercially available sources. This is of particular importance for those Enrollees with an unavailable, disconnected, or incorrect phone number.

Enrollees who screen positive for risks on the HRA (or those who request contact from a Humana associate) are automatically referred to our care management team. This team then conducts an Enrollee Needs Assessment to determine eligibility for one of our PHM Program risk tiers.

Welcome Call

We greet new Enrollees with a Welcome Call during which we provide information about Covered Services and value-added services (and how to obtain these services), the value of screening and preventive care, and other healthcare-related topics. If an Enrollee indicates wanting to learn more or an interest in selecting a PCP, they will be connected to an MSR for further assistance. Our MSRs will provide more detailed information about how the plan works, confirm receipt of the Welcome Kit, and attempt to capture Enrollee health data and preferred contact information. Our MSRs will also attempt to complete the HRA over the phone. If the Enrollee expresses an unmet healthcare need during the Welcome Call, we will connect them to our care management team for further assistance.

Methods of Completion

Recognizing the diverse preferences and locations of our Kentucky Medicaid membership, we offer multiple avenues for HRA completion. By making the HRA more convenient for our Enrollees to access, we aim to increase completion rates. We offer the following methods:

- Telephonically, either through an outbound call or by calling our Member Services Call Center
- Mail, using the copy of the HRA provided in the Welcome Kit
- In-person, with a Humana CHW, Community Engagement coordinator, or CM
- Online, through our Enrollee portal
- Smartphone applications, including our Go365® mobile application

Ongoing Opportunities to Complete the HRA

In addition to the formal mail and telephonic attempts that occur within the first 30 days of completion, we look for other opportunities to reach our Enrollees and promote HRA completion. These include:

- Inbound calls and visits to Humana Neighborhood Locations: Our Customer Relationship Management (CRM) system will alert our MSRs when an Enrollee with an uncompleted HRA contacts Humana's Member Services Call Center or visits a Humana Neighborhood Location. The MSR can help the Enrollee complete the HRA by telephone or complete it in person at a Humana Neighborhood Location.
- Transition planning: HRAs will be completed as part of the transition planning process for Enrollees who are moving between care settings, if the assessment was not previously completed.
- Online: Enrollees using our Enrollee portal and Go365® smartphone application will receive alerts and push notifications directing them to complete the HRA.
- Community Engagement team: Our Community Engagement team maintains regular contact with community organizations. As part of this contact, we will educate our community partners on the HRA process and the importance of completion and request their assistance in connecting with our Enrollees and directing them to a Humana associate for assistance with HRA completion.
- Network providers: We will educate our Kentucky network providers on the importance of HRA completion and how to connect with a Humana representative to complete and return HRAs.

Enrollees can visit two **Humana Neighborhood Locations** in the Commonwealth to complete the HRA – one in Louisville and one in Covington.

Enrollee Incentives

Humana is committed to completing HRAs within the contractually required timeframes for new Enrollees and annually thereafter. As such, **all Enrollees are eligible to receive a reward incentive, redeemed through our Go365® Enrollee incentive platform** (see **Figure I.C.24-6** for an example of the Go365® Mobile App user interface).

Unable to Contact (UTC) Process

Our experience in serving Medicaid populations has imparted an understanding of the challenges inherent in reaching certain cohorts within our membership. We have discovered value in screening our population even after contractual timelines may have passed. Therefore, our efforts to complete the HRA for an Enrollee will not end after the initial completion period has passed. After 30 days with no successful contacts, we will designate the Enrollee as UTC. Even after the Enrollee is designated UTC, we continue to attempt HRA completion through subsequent Enrollee interactions. We indicate those Enrollees with an uncompleted HRA in our system, alerting those associates who may interact with the Enrollee and prompting action to complete the HRA.

Our UTC approach leverages data mining techniques and our Kentucky relationships to successfully locate and engage difficult-to-reach Enrollees. These methods include locating updated contact information through the following data sources:

- Claims data, including pharmacy data
- Information collected during discharge planning
- Clinical data feeds from participating providers and hospitals, including BH data
- Online search engines (e.g., LexisNexis) to access government records, including death certificates and correctional facility admissions
- Reports of updated contact information from our strategic partners that provide our Medical advice line; BH Crisis Line; and prenatal and postpartum, dental, and vision services
- Contacting assigned PCPs, BH providers, pharmacies, and homeless shelters to determine if they have obtained updated or alternative contact information

Through our advanced data analytics systems and predictive models, we utilize our available data – including data from enrollment files and any received claims – to identify ESHCNs and Enrollees stratified to Intensive or Complex Care Management among our UTC population. Our CHWs will perform additional outreach for these Enrollees, including working with providers and community organizations, and employing other feet-on-the-street approaches to target difficult-to-find and UTC Enrollees. **Humana hires CHWs from the communities we serve to increase our ability to successfully connect with these Enrollees.** CHWs are trained to administer the HRA and identify Enrollee risks and SDOH needs.

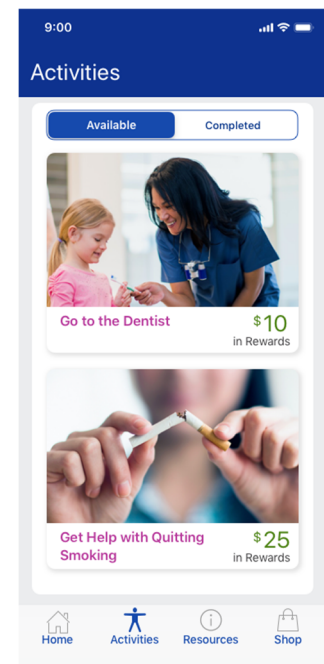
Pregnant Women

If we have a reasonable belief the Enrollee is pregnant, Humana will make all attempts to administer the HRA within 30 days, per requirements outlined in Section 34.3 PHM Program Tools of the Draft Medicaid Contract. If the Enrollee is determined to be pregnant, we will refer the Enrollee to appropriate prenatal care and invite them to participate in our **Kentucky Medicaid maternity care management program, MomsFirst** (open to all pregnant Enrollees). If the expectant mother is at risk for using alcohol, tobacco, and other drugs, we will refer them to the State's **KY-Moms Maternal Assistance Toward Recovery (KY-Moms MATR) program**.

Commitment to continuous quality improvement

In line with our commitment to continuous quality improvement, we will regularly evaluate and refine our outreach process to increase HRA completion rates with the support of Humana's corporate behavioral

Figure I.C.24-6
Go365 Mobile App



economics team. We assess differences in completion rates among Enrollee cohorts, including different geographic locations, age groups, races and ethnicities, language preferences, and eligibility categories and tailor our interventions appropriately.

HRA Completion: Applying Lessons Learned

To address less-than-desired HRA completion rates, our Florida Medicaid plan undertook a quality improvement process initiative to increase HRA completion rates for several key populations, including Enrollees with SMI, asthma, or diabetes and Enrollees who are pregnant.

By implementing focused call campaigns, including authorization of additional associate work hours to complete calls in the evenings and on weekends, our plan surpassed state benchmarks for these key populations. The success of this program and the lessons learned have a direct bearing on the process we will use to increase Kentucky completion rates. **We will complete a minimum of six outreach attempts (four by phone and two mailings) for all Enrollees, in addition to our other outreach efforts.**

HRA Completion Rates, Humana Florida Medicaid (December 2018)

Population	Completion Rate	Benchmark
Enrollees who are pregnant	78.7%	70%
Enrollees with SMI	67.2%	50%
Enrollees with asthma	53.7%	50%
Enrollees with diabetes	66.1%	50%

ENROLLEE NEEDS ASSESSMENT

After an Enrollee has been identified as eligible for one of our care management program levels and has agreed to participate, our CM coordinates with the Enrollee and their support system to identify a preferred date, time, and location to complete the Enrollee Needs Assessment and create the Enrollee's individualized care plan. The Enrollee Needs Assessment will be completed within 30 days of identification for care management. Depending upon the Enrollee's acuity level, the assessment may be completed by the following:

- Registered Nurse (RN)
- Nurse Practitioner (NP)
- Physician's Assistant (PA)
- Clinically Licensed BH Professional
 - Licensed Certified Social Worker-Clinical (LCSW-C)
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Marriage and Family Therapist (LMFT)
- Master's Level Behavioral Health professional with certification or licensure
 - LCSW-C
 - Certified Social Worker (CSW)
 - LPCC
 - Licensed Professional Counselor Associate (LPCA)
 - Licensed Clinical Alcohol and Drug Counselor (LCADC)
- Professional Counselor
- Licensed Psychological Practitioner
- Licensed Psychological Associate
- Associate with a graduate degree in social work or related field

Once the Enrollee Needs Assessment [to include supplemental assessments and surveys (if applicable) found in subsection I.C.24.a.iv.a] has been completed, the Enrollee's care plan will then be developed and finalized within

30 days of the assessment being finalized. When there is an indication that more immediate needs exist, Humana will make a reasonable effort to complete this assessment within an earlier timeframe. The Enrollee Needs Assessment will encompass all elements required by the Commonwealth in Section 34.3 PHM Program Tools, subsection C of the Draft Medicaid Contract and additional elements **(in bold type below within ‘Elements of the Enrollee Needs Assessment’)**, upon DMS approval, to more fully assess the needs, goals, and preferences of our Enrollees.

Humana employs multiple methods to encourage Enrollees to complete the Enrollee Needs Assessment including via telephone, in person (as needed or requested), or by other methodologies deemed appropriate by a Humana Kentucky Medicaid CM. Further, all Humana CMs receive training on **motivational interviewing** skills designed to engage Enrollees and help guide them through this assessment. Through a partnership with the **Bounce Coalition**, they will also receive specialized training on TIC. Through both initial training and ongoing coaching, our CMs are able to use communication techniques and behavior strategies to gather critical information needed to determine the most appropriate level of care and engagement. Humana also provides **cultural competency training** and provides a network of engagement supports, such as **translation services for more than 200 languages and American Sign Language (ASL) in person or via video**, that mitigate barriers to care resulting from language and cultural factors. Please see our response to subsection I.C.24.a.iv.e of the RFP for further details on Humana’s approach to cultural competency.

Our assessment focuses on identifying not only an Enrollee’s health needs, but also potential barriers to accessing and engaging in care. These include (but are not limited to) an Enrollee’s knowledge of their health condition(s), understanding of their treatment plan and the importance of adhering to that plan, and any challenges faced by the Enrollee in meeting basic needs, such as stable housing.

Elements of the Enrollee Needs Assessment

- Enrollee goals and preferences
- Review of SDOH needs, including housing, food insecurity, physical safety, transportation, education, and employment
- Psychosocial, functional, and cognitive needs
- Enrollee’s immediate and current health status, including condition-specific issues and ongoing needs requiring treatment or monitoring
- BH status, including screening for clinical depression (using the Patient Health Questionnaire-9), substance use disorder (SUD), serious emotional disturbance (SED) and other mental health conditions, and tobacco usage, among others
- Clinical history, including prescribed drugs and over-the-counter medications
- Current services, including other care management (i.e., State-based or provider-led), durable medical equipment (DME), and treatment plans
- Evaluation of caregiver resources, including adequacy, involvement, and level of decision-making
- **Assessment of the home environment**
- **Cultural and linguistic preferences**
- **Life planning activities, covering advance directives, legal assistance, financial planning, and family planning**
- **Hearing and visual preferences or limitations**
- **Service delivery preferences**
- **History of ACEs that may impact health**

PERIODIC REASSESSMENTS

Our CMs will conduct reassessments at least annually, as well as at Enrollee and/or representative request; upon change in needs or circumstances; or upon referral from a provider, caregiver, or social services agency. Through our proprietary integrated clinical platform, CGX, we will track assessment completion, schedule follow-up

contacts according to Draft Medicaid Contract requirements and Enrollee preference, and generate CM alerts when an Enrollee's date for reassessment is approaching.

IDENTIFYING CHANGES IN CONDITION

Humana has 10 primary routes for identifying changes in an Enrollee's condition that may trigger re-assessment to determine any needed change in risk level or services:

1. Submissions of authorizations for inpatient care, private duty nursing (PDN), community services, Prescribed Pediatric Extended Care (PPEC), or other specialty services
2. Change in an Enrollee's risk based on their Medicaid severity score
3. Change in an Enrollee's risk of a non-emergent ED visit
4. Change in an Enrollee's risk of developing opioid use disorder, as determined by our Opioid Predictive Model
5. ED encounters (when available)
6. Notification from our Medical advice line
7. Notification from our BH Crisis Line team
8. Notification from our pregnancy application partner, Pacify
9. Notification from a provider, the Enrollee, their family, or other natural or community supports
10. CMs and CHWs providing their contact information to Enrollees and their supports, encouraging them to reach out upon a change in condition or other health-related event such as an inpatient admission

These notifications will prompt outreach by a CM (or CHW when appropriate). After addressing any urgent care needs and ensuring the Enrollee is in a safe environment, the CM will re-assess to address any new or emerging needs. If care and/or social needs are identified, the CM will arrange appropriate services and supports to assist the Enrollee to improve outcomes. As needed, we will engage providers on the Enrollee's Multidisciplinary Team (MDT) (if applicable) to recommend services to meet the Enrollee's identified needs.

ENGAGEMENT METHODS

To meet the Enrollee where they are, Humana deploys a multi-channel approach involving virtual and community-based methods to engage our diverse Kentucky Medicaid population. Below are some of the distribution channels used as engagement methods for our pregnant Enrollees, children and their support systems, homeless individuals, adults 19 to 65 years of age, and individuals with BH conditions.

Table I.C.24-3: Engagement Methods for Kentucky Medicaid Target Populations

Population	Distribution Channels
Pregnant Women	<ul style="list-style-type: none"> • Tailored materials distributed at Humana-sponsored events such as Baby Showers • Distribute materials on prenatal care, postpartum care, postpartum depression (PPD), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for newborns, and family planning • Mobile applications such as Pacify
Children, Parents, and Caregivers	<ul style="list-style-type: none"> • Materials tailored to various cohorts and age groups <ul style="list-style-type: none"> ○ School-age children (e.g., EPSDT periodicity schedule) ○ Adolescents (e.g., materials on bullying, suicide prevention, nicotine, and tobacco usage distributed at locations frequented by children and their parents) ○ Caregivers (e.g., care plans, upon Enrollee consent) ○ Legal Guardians (e.g., care plans and materials to manage chronic conditions) • Back-to-school community events • School-based clinics and school health fairs • Community resources like YMCA, libraries, and community recreation centers • Mobile applications such as Go365®

Population	Distribution Channels
Homeless Individuals	<ul style="list-style-type: none"> Tailored materials to address SDOH needs Pamphlets left at shelters and/or community housing partners Onsite events at local food banks and community centers Participation in events organized by FQHCs
Adults 19 to 65	<ul style="list-style-type: none"> Tailored materials distributed at community partners such as the Salvation Army Onsite events at community colleges and local job fairs
Enrollees with BH Conditions	<ul style="list-style-type: none"> Tailored materials to include community resources for BH and our direct-to-consumer telehealth services (MDLIVE) Leave-behind materials at shelters, FQHCs, and community recreation centers Participation in condition-specific events (SUD awareness event) Participation in events held by community partners and FQHCs

a.iv.

The Contractor's approach to each of the three PHM Program defined risk levels: health promotion and wellness, management of chronic conditions, and complex care management. Include information about the following for each risk level

a.iv.a.

Tools the Contractor will use to identify Enrollees and their risk levels and to support services provided

INITIAL STRATIFICATION

Humana applies a variety of tools to identify Enrollees who may benefit from four of our PHM Program tiers to include their coinciding risk levels:

- Health Promotion and Wellness**
- Management of Chronic Conditions**
- Intensive Care Management (exceeds Contract requirement)**
- Complex Care Management**

Our initial stratification relies on enrollment data included on the State 834 file and the completed HRA and Enrollee Needs Assessment. This information quickly identifies ESHCN, Enrollees who are pregnant, and other priority populations for our Kentucky Medicaid program. This initial stratification prioritizes our outreach efforts and also identifies those Enrollees best suited for our lowest-risk PHM tier, Health Promotion and Wellness. A summary of Humana's Enrollee PHM stratification can be found in **Table I.C.24-4** above.

Table I.C.24-4: Humana Enrollee PHM Stratification

Risk Tier	Percent of Membership
Health Promotion and Wellness	83%
Management of Chronic Conditions	8%
Intensive Care Management	8%
Complex Care Management	1%

PREDICTIVE MODELS

In addition to these tools, Humana conducts an ongoing review of our membership's characteristics, utilization, and demographics to generate a quantifiable level of risk. The primary predictive model we use across our Medicaid population is our proprietary **Medicaid Severity Score Predictive Model**. This allows us to create a severity score based on physical health, BH, pharmacy claims, SDOH needs, and other data to identify Enrollees with changing care needs who may benefit from care management. Our **Readmission Predictive Model** uses more than 50 variables to assess the probability of a readmission to a facility within 30 days of discharge. We use this score, coupled with our transitional care management, to prioritize our post-discharge outreach efforts and support referrals for ongoing care management. Our **ED Predictive Model** prospectively identifies Enrollees

who are likely to use EDs, become high ED utilizers, and/or use EDs for non-emergent reasons, which are considered identifying factors for care management. Our **Opioid Predictive Model** reviews pharmacy claims data to identify Enrollees at risk of opioid use disorder. We discuss these tools in more detail in our response to I.C.24.a.iv.b of the RFP.

ADDITIONAL TOOLS TO IDENTIFY RISK LEVELS

Supplemental Assessments, Surveys, and Methods

Humana Kentucky Medicaid CMs will also administer supplemental assessments, surveys, and methods (when deemed appropriate) to identify more complex Enrollee conditions, care needs, and specialized services and supports for those who stratify with high risk factors. These additions can include the following:

- **Social Needs Assessment**: A survey administered by our CMs, CHWs, and SDOH coordinators for Enrollees with identified SDOH needs, conducted as needed.
- **BH Crisis Plan Survey**: To develop a comprehensive crisis plan, our CMs guide Enrollees with BH diagnoses through this survey to identify steps that can be taken to prevent a BH admission or mitigate a future crisis situation.
- **SUD Survey**: Our CMs utilize this survey with Enrollees who participate in Humana's Go365® SUD program to help track their participation and progress toward their goals.
- **Consent and Disclosure**: For individuals with BH conditions, our care management team uses this assessment to request permission from Enrollees to share sensitive information with our providers to improve care delivery and outcomes.
- **MomsFirst Surveys**: Performed by our MomsFirst CMs, maternity-specific surveys are given to Enrollees during the prenatal, immediate postpartum, and six weeks postpartum stages. Topics include:
 - Pregnancy history
 - Psychological growth and developmental assessment
 - Family planning and birth spacing education
 - Invitation to participate in our Humana Kentucky Medicaid MomsFirst Program
 - Needed referrals to community partners and State agencies, such as SNAP, WIC, and the Commonwealth's KY-Moms MATR program for Enrollees using tobacco, alcohol, or other substances
- **Pediatric Enrollee Needs Assessment**: For our pediatric Enrollees who stratify as high risk, we will conduct a specialized pediatric assessment to evaluate the need for additional services and supports.
- **Discharge Planning Assessment**: For inpatient stays, our UM nurses will initiate discharge planning for Enrollees prior to discharge. In Kentucky, **we will place UM nurses onsite in high-volume facilities** (with facility permission) to provide face-to-face discharge planning. If the Enrollee is being discharged from a psychiatric facility, Humana will assign a CM, even if the Enrollee is not engaged in care management at that time.
- **Integrated Post-Discharge Survey**: Through the development of the discharge plan, we will identify Enrollees with rising or changing risk who may newly benefit from care management. This integrated survey is administered by our CMs within 72 hours of discharge.
- **Environmental Survey**: Administered as needed, our CMs and CHWs are trained to perform this survey to identify and document risk factors in the home (i.e., safety concerns) that could adversely impact health and well-being outcomes of Enrollees. This important tool will help our care management team arrange services and supports that alleviate these factors when possible.
- **Re-determination Assessment**: Occasionally, an Enrollee may be dis-enrolled from Humana for a short period of time as a result of Enrollee choice, a temporary change in their eligibility, or an unintentional lapse in re-enrollment. If the Enrollee previously engaged in care management re-joins Humana within 90 days following disenrollment, they will be automatically identified for engagement in care management without additional screening. To mitigate unintentional dis-enrollments because of a lapse in coverage, our CMs receive an alert via CGX to reach out and offer needed assistance, including support with re-enrollment, when an assigned Enrollee has been dis-enrolled.

- Medical advice line and BH Crisis Line notifications: Each Enrollee who has contacted our Medical advice line or BH Crisis Line will receive a follow-up call on the next business day to offer assistance and evaluate the Enrollee's ongoing needs, including the potential to benefit from care management and/or SDOH support.

Humana provides supports tailored to each level of need, including condition-specific assistance. A more detailed discussion of services provided and their frequency can be found below in our responses to I.C.24.a.iv.d and I.C.24.a.iv.h of the RFP.

Core Supports

We will provide a core set of supports for all of Enrollees in care management, in addition to tier-specific services described in Table I.C.24-5 below. Core supports include:

- Care coordination (navigating the healthcare system)
- Education on available benefits, including value-added services (for more details on our value-added service offerings, please see our response to I.C.20 Covered Services of the RFP)
- Disease-specific education and self-management support, including linkage with educational materials provided through **KidsHealth®** and **Healthwise®**, and referrals to classes conducted by our Kentucky Medicaid Community Engagement team at Humana Neighborhood Locations and other community centers
- Support from a CHW or provider-led Peer Support Specialist (as needed and upon provider approval), as indicated and with Enrollee consent
- Referrals to resources to address SDOH, including support from a Humana SDOH coordinator or Housing specialist
- **Transitional care support**, including:
 - Coordination of aftercare services for Enrollees preparing for discharge from a psychiatric residential treatment facility, therapeutic group home, or intermediate care facility
 - Follow up within 72 hours following discharge/transition, with additional follow up as detailed in the discharge plan
 - Support from a Kentucky Medicaid Housing specialist for Enrollees identified as homeless at time of care transition
 - Screening for youth in out-of-home placement or at risk of an out-of-home placement

Table I.C.24-5 – Enrollee Supports for each PHM Program Risk Tier

Tier 1: Health Promotion and Wellness	<p><u>Support Provided:</u></p> <ul style="list-style-type: none"> • HRA inclusive of the Enrollee's physical health, BH, and SDOH needs • Outreach from our Kentucky Medicaid SDOH coordinators to support identified SDOH needs • CM outreach upon notification of a change in Enrollee condition or upon request of the Enrollee, Enrollee's authorized representative, or an MDT member • Ongoing predictive modeling for risk stratification to identify a change in condition or the need for CM outreach
Tier 2: Management of Chronic Conditions	<p><u>Support Provided:</u></p> <ul style="list-style-type: none"> • All Tier 1 supports • Frequency of contact, educational support, community resources, and other needs for follow up are identified during the Enrollee Needs Assessment and supplemental assessments (when applicable) • Refinement of services and supports based upon CM judgment and Enrollee preferences • Chronic condition management programs • Outreach by CM/CHW bi-annually (at a minimum) with more frequent outreach as needed • Supportive educational mailings • Face-to-face engagement when needed or requested by the Enrollee

Table I.C.24-5 – Enrollee Supports for each PHM Program Risk Tier

Tier 3: Intensive Care Management	<p><u>Support Provided:</u></p> <ul style="list-style-type: none"> • All Tier 1 supports • Frequency of contact, educational support, community resources, and other needs for follow up are identified during the Enrollee Needs Assessment and supplemental assessments (when applicable) • Refinement of services and supports based upon CM judgment and Enrollee preferences • Chronic condition management programs • Outreach by CM/CHW on a quarterly basis (at a minimum) with more frequent outreach as needed • Supportive educational mailings • Face-to-face engagement when needed or requested by the Enrollee
Tier 4: Complex Care Management	<p><u>Support Provided:</u></p> <ul style="list-style-type: none"> • All Tier 1 supports • Frequency of contact, educational support, community resources, and other needs for follow up are identified during the Enrollee Needs Assessment and supplemental assessments (when applicable) • Refinement of services and supports based upon CM judgment and Enrollee preferences • Chronic condition management programs • Outreach by CM/CHW on a monthly basis (at minimum and more frequently as needed) • Supportive educational mailings • Face-to-face engagement when needed or requested by the Enrollee

Provider Support Services

To provide support for our in-network PCPs and BH providers, Humana will employ a **dedicated Practice Innovation Advisor**. Our Practice Innovation Advisor will collaborate with providers to:

- Review and adapt operating procedures to promote physical health, BH, and SDOH integration
- Facilitate trainings for practice staff on physical health and BH integration, to include education on various tools to enhance care delivery
- Support providers to negotiate data-sharing or care team agreements with other providers, including identification of BH providers interested in partnership
- Offer **statewide workshops in Patient-Centered Medical Home (PCMH) accreditation**, including at least one held in the first year of the Draft Medicaid Contract

a.iv.b. Risk stratification methodology and descriptions of the types of data that will be used

Humana uses various risk stratification methodologies to assign a PHM Program tier aimed at health promotion and wellness, management of chronic conditions, intensive care management, and complex care management. After initial stratification and assignment, Humana continues to reassess and refine the stratification. We evaluate all factors that may impact an Enrollee's health or well-being. The CM reassesses the Enrollee and considers re-stratification upon Enrollee request, a significant change in needs or circumstances, a change in risk score, or through consultations with providers and the Enrollee's MDT. Our full risk identification, stratification, and risk assignment methodology is depicted in **Figure I.C.24-7**.

Table I.C.24-6 Humana’s Risk Stratification Methodology

Incorporates the following types of data and sources in alignment with NCQA PHM Program standards:		
Medical, BH, and pharmacy claims	SDOH data	Electronic Health Records (EHR)
Health Information Exchange (HIE)	Care Management	Wellness and Prevention programs
Enterprise Data Warehouse (EDW)	Data supplied by Enrollees, Parent/Guardian, Caregiver, or other natural supports	Data supplied by DMS (834 file), State Agencies, Providers, and Community Organizations
Utilization Management (UM), to include Admission, Discharge, and Transfer (ADT) feeds	Laboratory data	Demographic and Census data

Our **suite of proprietary predictive models supports** a continuous review of our membership’s characteristics, utilization, and demographics to generate a quantifiable level of risk. By applying these models in concert with one another, Humana can readily identify Enrollees with new, rising, or changing risk patterns and inform our outreach for care management and/or SDOH supports.

Medicaid Severity Score Model

- **Methodology:** **Humana’s Medicaid Severity Score Model** is the primary predictive model we use across our entire Medicaid population. Using this proprietary model, we incorporate a severity score generated from available physical health, BH, and pharmacy claims; UM data; lab results; and other data sources into monthly reports that identify the Enrollees most likely to have high costs and/or clinically complex health conditions over a rolling 12-month period. To address the challenges of modeling for a diverse population, we have designed our model to group Enrollees based upon certain characteristics and build individual models for each group. For new Enrollees with limited historical data, we will rely on third-party Enrollee- and community-level data Humana purchases to develop a severity score.
- **Severity Risk Score:** Range of zero to 100
- **Application:** We use the scores generated by this model to identify Enrollees with changing care needs who may benefit from care management, move Enrollees between acuity levels, and alter Enrollees’ care management tiers, as appropriate.

Readmission Predictive Model

- **Methodology:** **Humana’s Readmission Predictive Model** assesses the probability of an Enrollee’s readmission into a facility within 30 days. This is a true predictive modeling process with inputs across more than 50 variables including demographics such as the Enrollee’s age and gender; previous physical health, BH, and pharmacy claims, including physician visits; admissions; days since last admission; the Charlson Comorbidity Index (a validated instrument regarding co-morbidities); number of medications; and information regarding their current admission [procedure, diagnosis, bed type, length of stay (LOS), and discharge disposition]. The model runs throughout the course of the Enrollee’s admission, taking into account any updates to the inpatient authorization and generating a numerical score that allows us to assess the risk of all-cause readmission within 30 days.
- **Readmission Risk Score:** High (> 170), medium (170 to 154), and low (< 154) acuity levels
- **Application:** We will combine this score with information gathered through transitional care management to prioritize our post-discharge outreach efforts and support referrals for ongoing care management. Enrollees with a risk for readmission will be further evaluated for care management, in accordance with the objective measures and criteria described below.

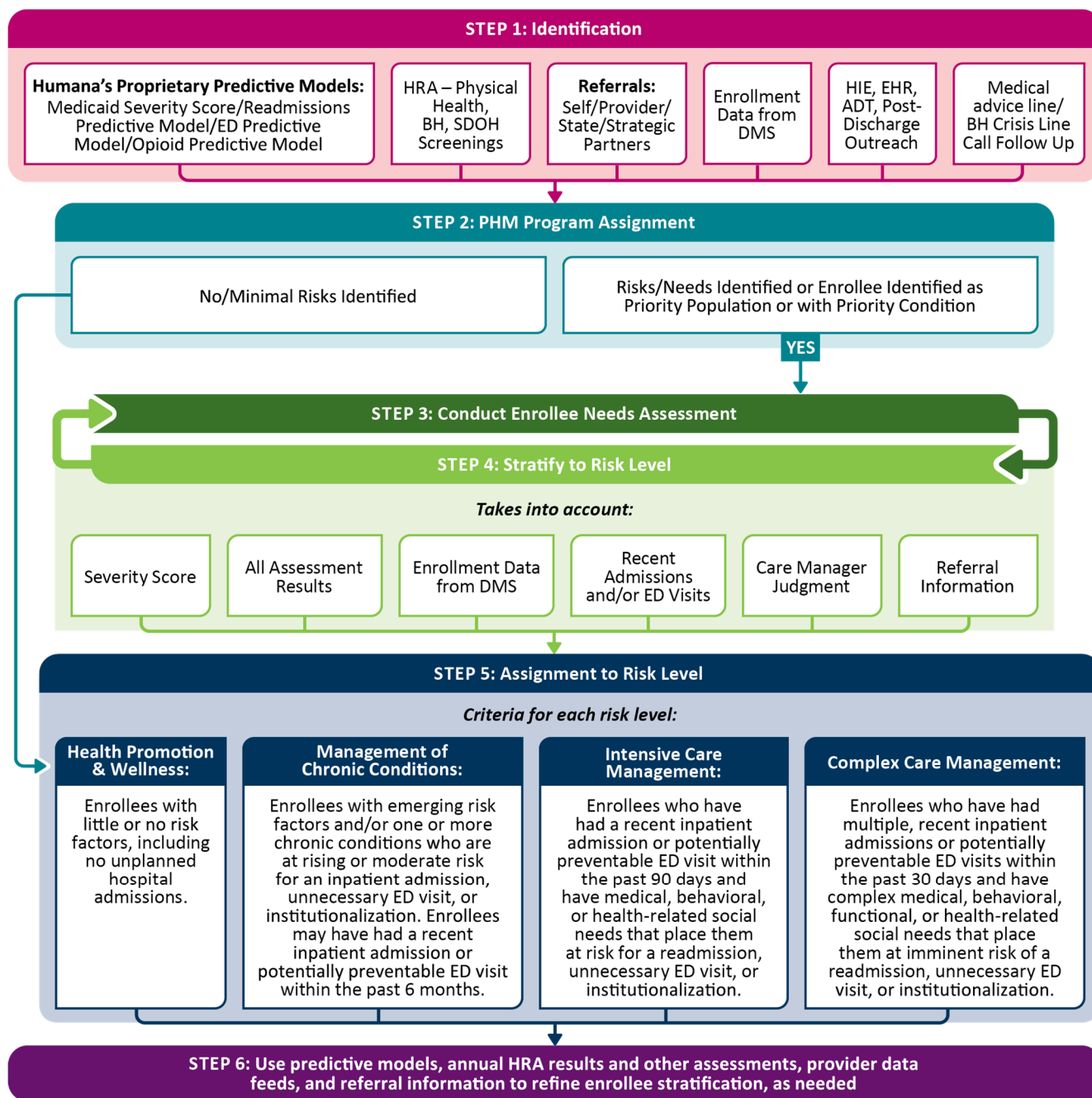
ED Predictive Model

- Methodology: We run our **ED Predictive Model** monthly to prospectively identify Enrollees who are likely to use EDs, become high ED utilizers, and/or use EDs for non-emergent reasons. The model creates a profile of each Enrollee that includes cost and utilization for different physical health and BH conditions as well as socioeconomic profiles.
- ED Risk Score: Range of zero to 1,000
- Application: We consider risk of non-emergent ED use as an identifying factor for care management and subsequent stratification.

Opioid Predictive Model

- Methodology: **Humana's Opioid Predictive Model** identifies Enrollees at risk for diagnosed opioid use disorder by utilizing pre-diagnosis characteristics and behaviors of the diagnosed individual during the time period of 30 to 210 days prior to diagnosis.
- Opioid Risk Score: Ranking of 10 (highest risk), 9, 8, or zero (no risk identified)

Figure I.C.24-7: Humana’s PHM Program Enrollee Identification, Stratification, and Risk Assignment



a.iv.c. Methods to identify Enrollees for each of Kentucky’s priority conditions or populations.

Humana has processes and methods in place to appropriately identify and care for Enrollees with priority conditions, including asthma, heart disease, diabetes, obesity, tobacco use, cancer, infant mortality, low birthweight, BH, SUD, and other conditions that Humana has included in our Kentucky Medicaid model or as determined by the Department. See our response to I.C.24.a.iv.b for all identification methods.

In addition to the priority conditions listed in Section 34.2 Conditions and Populations of the Draft Medicaid Contract, Humana will also consider the following conditions and populations to be priorities among our Kentucky Medicaid membership:

- All pregnant women, especially Enrollees considered high risk as determined by their providers
- At-risk/imminent-risk children (for out-of-home placement)
- Birth outcomes and NAS
- ESHCNs
 - Children in/or receiving Foster Care or Adoption Assistance, if applicable
 - Blind/Disabled Children under the age of 19 and related populations eligible for SSI
 - Adults over the age of 65
 - Individuals experiencing homelessness (upon identification)
 - Individuals with chronic physical health illnesses
 - Individuals with chronic BH illnesses
 - Children receiving EPSDT Special Services
 - Children receiving services in a PPEC facility or unit
 - Adult guardianship clients
 - Enrollees with chronic BH illnesses, including Enrollees with SMI residing in institutions or at risk of institutionalization
- HIV/AIDS
- Hepatitis C
- Persons who inject drugs

In 2018, our Kentucky Medicaid Enrollees reported the following:

- **24%** reported tobacco use
- **21%** are obese
- **27%** have a BH diagnosis
- **17%** have a chronic condition
 - **8%** with diabetes
 - **6%** with asthma

Of our Enrollees with a BH need:

- **46%** have SUD
- **37%** have SUD co-occurring conditions, such as tobacco use and obesity

Infant mortality and low birthweight

Humana has processes designed specifically for infant health-related priority conditions, including infant mortality and low birth weight. Our processes begin with outreach to pregnant Enrollees. In addition to those who self-attest, we prioritize identifying pregnant Enrollees early in their pregnancy through:

- Claims review: For example, CMs will flag Enrollees who fill a prescription for prenatal vitamins
- OB/GYN education: Provider Relations representatives visit OB/GYN offices to educate providers on MomsFirst and encourage referrals. MomsFirst CMs will be available as needed to visit with Enrollees at OB/GYN offices.
- Provider incentives: Providers receive a monetary incentive to complete and return the Notice of Pregnancy form.

We offer our maternity care management program MomsFirst to all pregnant Enrollees, with contact frequencies tailored to the Enrollee's level of risk. **Humana CMs will refer expectant mothers using alcohol, tobacco, or other drugs to KY-Moms MATR, while continuing to monitor their care and facilitating regular check-ins.**

We identify babies born and placed in NICU using prior authorization (PA) requests, claims, encounters, and hospital notifications. Our NICU program exemplifies how we improve our Enrollee's health through the intersection of UM and care management. After we are notified of the baby's admission to the NICU, there is ongoing clinical review through the inpatient stay for medical necessity, care coordination, interventions, and discharge planning. The NICU nurse and CM participate in weekly rounds with **Lisa Galloway, MD, (our Kentucky Medicaid Medical Director)**, and post-discharge the CHW, UM/Transition Coordinator, or CM (based on risk level and the needs of the infant) follow up with the parents within 48 hours and again at 14 to 21 days after discharge to ensure the necessary follow-up care and supports are in place. We work with all areas of the infant's care team, including social workers, discharge planners, nurses, physicians, and the home

Humana has seen significant improvement in maternity outcomes. From 2017 to 2018, Humana Enrollees experienced a **33% decrease in low birthweights** and a **32% decrease in NICU admissions**. Additionally, there was an **18% reduction in NAS deliveries**.

health agency to ensure the infant receives medically necessary, evidence-based treatment and once home, continues to receive all needed care. If the infant is readmitted within the first 30 days after discharge, our NICU team manages the readmission. The CM continues to perform outreach to the Enrollee and the family up to the infant's first birthday (assuming continued Humana eligibility).

To target broader interventions and supports, such as Community Baby Showers and health education events, Humana employs data analytics to identify maternity-specific issues across the Commonwealth and implement appropriate interventions. We track critical trends such as low birthweight births, NAS, infant mortality, and NICU admissions and identify drivers of these outcomes to inform our interventions and approach.

A 2016 IPRO/DMS review found that one-quarter of our pregnant Kentucky Medicaid Enrollees were identified smokers. To address this pressing issue, we are implementing a performance improvement project (PIP) that uses provider and Enrollee education, improved screening techniques, better Enrollee outreach, and engagement in maternity care management to encourage use of smoking cessation services. Our interim evaluation found a **48% increase in the rate of tobacco use screenings during prenatal visits**. Among Enrollees who received an intervention for tobacco cessation, we saw a **76% increase in those who abstained from smoking for the rest of their pregnancy**.

Priority Populations

In addition to focusing on priority conditions, Humana will develop policies and procedures to prioritize care for high-need populations.

- **ESHCN:** Please refer to our response to Section I.C.25 ESHCN of the RFP for more details regarding our approach to the identification, assessment, and care coordination for ESHCN, including adults and children. We identify these Enrollees using a range of data sources including enrollment files, the HRA, and historic claims. Ongoing methods of identification include predictive models, post-discharge screening, claims and encounter data, provider and other agency referrals, and Enrollee self-identification.
- **High-Risk Pregnant Women:** We will identify high-risk pregnant women using the Notice of Pregnancy form submitted by providers and other methods discussed above. As noted above, to encourage the widespread use of this notification, Humana incentivizes providers to complete and return the form. In addition, we will screen for risk factors during the Enrollee Needs Assessment that will be administered to all pregnant Enrollees (with consent), to identify a history of preterm labor, diabetes mellitus, a history of pregnancy loss, heart disease, multiple gestation, autoimmune disease, a BH diagnosis, or SDOH needs.

We will periodically assess our Enrollee population to determine additional priority populations that can benefit from targeted interventions and support. Additional priority populations will include:

- **All pregnant women:** As described above, we will aim to identify all pregnant Enrollees early in their pregnancy to encourage early prenatal care and engagement in our MomsFirst care management program. Enrollees will be identified using the HRA, claims review, provider notification, and self-referrals. Our MomsFirst CMs will monitor reports from Pacify, a maternity smartphone application offered to our Enrollees, to identify pregnant women using the application who have not yet engaged in care management and outreach accordingly. Humana recognizes the tremendous value in prioritizing care early and often for pregnant woman and the far-reaching impact of care coordination during pregnancy.
- **At-risk/Imminent-risk children:** While annual rates of out-of-home placement for children have increased nationally, Kentucky's placement rates have far outpaced the national average. **Between 2011 and 2017, Kentucky experienced a 24.5% increase in out-of-home placements**. To address this concern in the Commonwealth, we will identify children at risk for out-of-home placement using the following data sources:

As of 2018, 12% of our pregnant Kentucky Medicaid Enrollees had a diagnosis of SUD, while 14% had a diagnosis of SMI.

- Pediatric version of the Enrollee Needs Assessment
- Claim reviews for Enrollees with SED, as they are likely at a higher risk for out-of-home placement
- Inpatient, outpatient, and residential BH and SUD data (when available)

By identifying at-risk children sooner, Humana can leverage our care management team and processes to support the Commonwealth's implementation of the Family First Prevention Services Act and coordinate with providers of family reunification services.

- Persons who inject drugs: We will identify individuals who inject drugs through questions concerning drug use on our Enrollees Needs Assessment, including method of use. In addition, we will aim to build partnerships with organizations serving this vulnerable population to encourage referrals of Humana Enrollees for care management. **According to the Centers for Disease Control and Prevention (CDC), Kentucky has one of the highest rates of injection drug use in the country, placing the Commonwealth at a high risk of an HIV/hepatitis C outbreak. The CDC identified and ranked the 220 counties in the country most vulnerable to an HIV/hepatitis C outbreak; 54 of the counties are in Kentucky, including eight of the top 10.** Prioritizing engagement with this population will help Humana protect the health of persons who inject drugs and our communities through medical and behavioral interventions and, in the long term, reduce harm and promote needed BH services. These efforts will directly overlap with our Homeless Outreach Plan.
- Post-incarceration Population: We will identify Enrollees re-entering the community following incarceration through notification from DMS and Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and via our participation in the joint DMS, DBHDID, and Department of Justice re-entry pilot. Our participation in this pilot is further described in our response to I.C.25 of the Request for Proposal.
- Enrollees with extraordinary SDOH needs: We will identify Enrollees with complex or intensive SDOH needs that limit their ability to manage any chronic conditions or put their health at risk through our HRA and Enrollee Needs Assessment. These Enrollees will receive focused support from the CM to address their SDOH needs, with the support of an SDOH coordinator and CHW (as indicated).
- Enrollees with limited access to care: Enrollees who are homebound, live in a rural area without access to transportation, or face other restrictions to accessing care will be targeted for support from an SDOH coordinator upon identification through our HRA, Enrollee Needs Assessment, or outbound or inbound calls from Humana associates to close care gaps. We will aim to link these Enrollees with transportation assistance, mobile services, home services, or other options to resolve their barriers to receiving care.



ASSOCIATE SPOTLIGHT:
Bridgett King-Daily, CSW, BH Field Care Manager

Bridgett serves as one of Humana's Kentucky Medicaid BH Field Care Managers and has seven years of experience supporting SUD populations. In past roles, she devised, implemented, and monitored an SUD recovery program for the Louisville Metro Jail, in addition to implementing a NAS program for a recovery organization.

Staying informed of advances in evidence-based treatments and optimal care models related to SUD, Bridgett continues to update her knowledge through journals, workshops, seminars, and volunteer work. She is passionate about her path of service, empathetic to the risks, obstacles, and barriers individuals with BH issues encounter. A veteran of the U.S. Army, born and raised on Army bases, Bridgett states:

“ This experience resulted in a sense of discipline, responsibility, and respect for others, helping me engage with diverse populations and see the good in all. ”

a.iv.d. Services and information available within each risk level

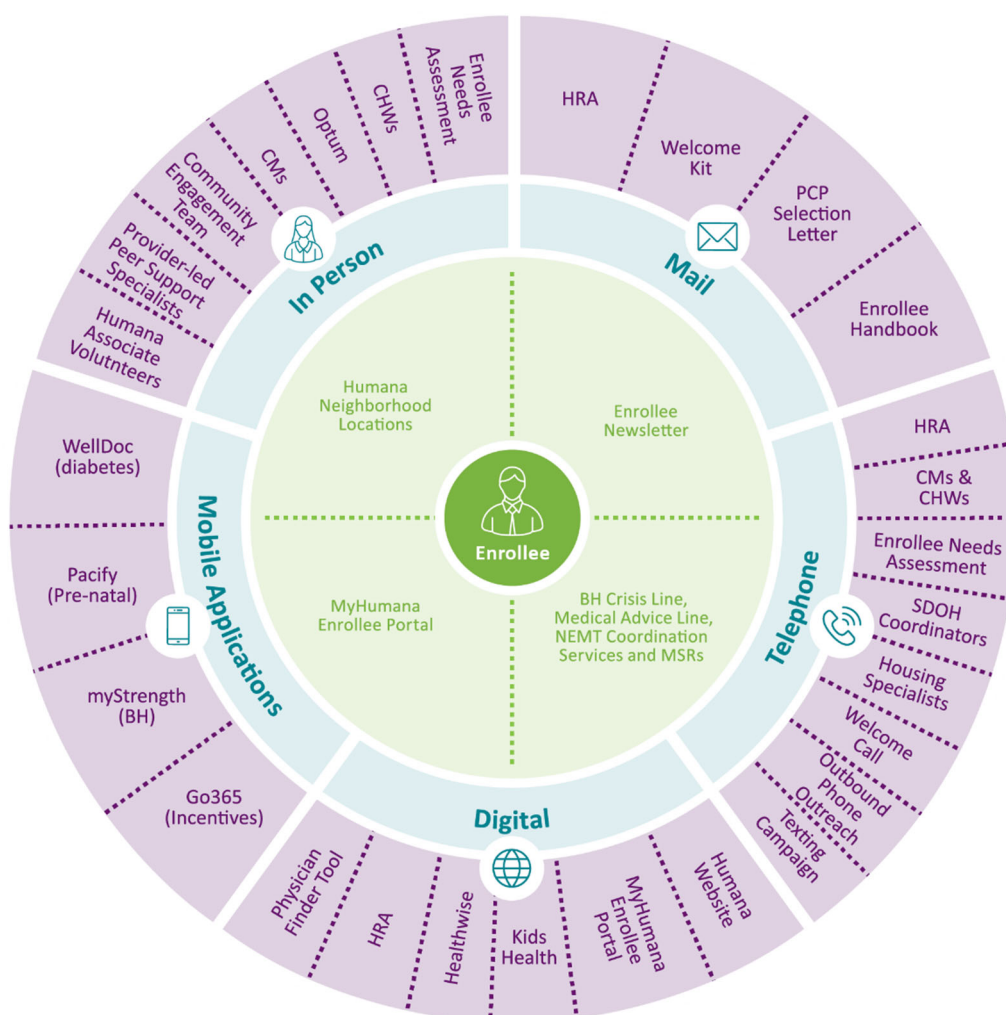
ENROLLEE SUPPORT MODEL

Humana's PHM Program is designed to provide services and supporting information to our entire Medicaid population, recognizing the Enrollee level of need and tailoring outreach accordingly. Humana's programs are based on delivering a Perfect Experience, which reflects our commitment to helping Enrollees achieve their optimal health and well-being. A visual of our PHM Program Enrollee Supports can be found in **Figure I.C.24-8** below. Through our Perfect Experience initiative, which originated in 2006, we conduct systematic training and monitoring around all aspects of Enrollee contact. The following principles guide all that we do:

In 2019 and 2020, **Newsweek ranked Humana #1 in customer service** among health insurance companies.

- **Know Me:** Meet the Enrollee where they are and anticipate their needs
- **Show Me You Care:** Listen to the Enrollee, be transparent, and do right by the Enrollee
- **Make it Easy:** Connect the dots, coordinate activities with and for the Enrollee, supply context, and reduce complexity
- **Help Me:** Help the Enrollee understand, be the Enrollee's advocate, and be proactive to solve issues

Figure I.C.24-8 Humana's Kentucky Medicaid PHM Program Enrollee Supports



PHM PROGRAM RISK TIERS

Tier 1: Health Promotion and Wellness

The following services are available to all Medicaid Enrollees, including those in our Health Promotion and Wellness tier, and are designed to empower Enrollees to manage their health and well-being. Services include:

- Medical advice line
- BH Crisis Line
- Community resource support
- Care coordination assistance
- Coordination with Non-Emergency Medical Transportation (NEMT) and other carved-out services
- Condition-specific education and guidance
- Community education events
- Support from Humana CHWs, SDOH coordinators, and Housing specialists
- Enrollee and provider incentives for preventive care
- Education on available benefits, including value-added services
- Health and social needs literacy

Humana offers a wide range of health information, made available through digital and print platforms and delivered by our associates. These information platforms include (but are not limited to):

- **KidsHealth®**: A library of video modules and written content on pediatric BH and physical health conditions. **KidsHealth®** content is designed to be accessible and readable by children, adolescents, and adults, enabling our younger Enrollees to play a role in the self-management of their condition.
- **Go365®**: **Humana's wellness and rewards program, Go365®**, incorporates practices of behavioral economics and encourages Enrollees to complete healthy activities, including preventive exams and the completion of the HRA. The custom Medicaid Go365® mobile app provides an experience designed to specifically meet the needs of our Kentucky Medicaid Enrollees. Upon completion of key activities, participants can earn and redeem gift cards to popular retailers, such as Walmart, Shell, and Amazon.com, which we can deliver via email or mail.
- **MyHumana**: Humana's mobile application (see interface example I.C.24-9 MyHumana Mobile App to the right) enables Enrollees to manage their healthcare virtually anywhere, anytime. **Fully customizable, MyHumana** lets Enrollees establish the layout of their personal app, prioritizing the features most important to them. Accessible on any smartphone device, Enrollees can:
 - Access their Enrollee identification (ID) card
 - Send their Enrollee ID card to their provider through fax
 - Find an in-network doctor, pharmacy, dentist, hospital, urgent care center, or retail clinic based on their current location
 - View medical, dental, and pharmacy claims
 - View plans and coverage details, including deductibles
 - Communicate with Humana MSRs in real time

Additional resources are summarized in **Table 1.C.24-7** below.

Figure I.C.24-9
MyHumana Mobile App

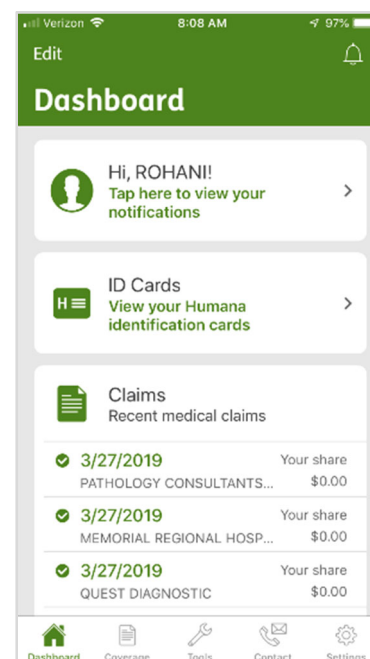


Table I.C.24-7: Health Information Resources

Category	Available Resources
Informational Materials	<ul style="list-style-type: none"> • Enrollee Handbook • Enrollee newsletters • Caregiver toolkit
Informational Media	<ul style="list-style-type: none"> • Social media • Digital platforms, including the Enrollee Portal (MyHumana), Pacify, and myStrength
Inquiry-based Information	<ul style="list-style-type: none"> • Medical Advice Line • BH Crisis Line • Member Services Call Center • Humana CHWs, SDOH coordinators, and Housing Specialists • Community Partners
Community Resource Directory (CRD)	<ul style="list-style-type: none"> • Partnership with United Way of Kentucky to broaden 2-1-1 CRD • Community Engagement team expanding community partnerships and our CRD • United Community Louisville pilot for closed-loop resource referrals
Access to Educational Information	<ul style="list-style-type: none"> • Healthwise® Knowledgebase • KidsHealth® • Go365®, including Craving to Quit® smoking cessation program

Tier 2: Management of Chronic Conditions

In addition to the services listed above, Humana’s Chronic Condition Management programs include the following services:

- One-on-one health education from a Humana CM or CHW with **face-to-face engagement** (as needed and/or requested by the Enrollee)
- Care coordination support from an assigned CM, including navigation of the healthcare system
- Assistance in coordinating with providers and state agencies
- Access to **virtual care management**
- **Home health visits** (as medically necessary)
- Individualized care plan



ASSOCIATE SPOTLIGHT: Lauren Siegman, RN, Field Care Manager

Lauren serves as one of Humana’s Kentucky Medicaid RN Field Care Managers. She has 10 years of experience with in-home care and care management. She previously worked with the adult population to support effective management of chronic conditions. Excited to continue this work in her position as a Humana CM, Lauren appreciates that her role is critical to providing services and supports for individuals with extensive needs and to improve the overall health and well-being of communities throughout the Bluegrass State.

Based on the Enrollee’s specific condition, Humana provides targeted chronic condition management interventions. These interventions are Enrollee-centric and in-line with Humana’s person-centered model of care focused on behavior change and self-management. Our programs include supports for:

- Acquired and congestive heart failure
- ADHD
- Asthma and chronic obstructive pulmonary disease (COPD)
- Depression/postpartum depression
- Diabetes
- Hepatitis C
- HIV/AIDS
- Hypertension
- Pregnancy
- Post-traumatic stress disorder (PTSD) and ACEs
- SED/SMI
- SUD, including opioid use disorder and injectable drug use

To support these efforts, Humana has a range of tools and services available to support condition-specific care, education, and condition self-management, including:

- Healthwise®: Provides **disease-specific education and self-management support** in an easy-to-read format. It is available across priority conditions and follows current clinical practice guidelines (CPG). Our CMs use the Healthwise database to deliver condition-specific content to our Enrollees.
- myStrength: The **myStrength** digital platform (see **Figure I.C.24-10** for an example of the myStrength Mobile App user interface) will enable Humana Enrollees to access online learning, evidence-based support, and resources specific to their conditions (including SUD, depression, anxiety, and insomnia, among others) and **text-based one-on-one coaching**, supporting Enrollees in management of their BH conditions
- Optum®: Our partnership with Optum delivers in-home provision of **17P injections** for pregnant women at risk of pre-term birth
- Pacify: Humana will offer our pregnant and parenting Enrollees (with a child up to one year of age) 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. Pacify has demonstrated significant reductions in ED claims and inpatient claims among Medicaid Enrollees as well as increases in exclusive breastfeeding rates. Our MomsFirst CMs will monitor Pacify reports to identify Enrollees who are using Pacify but may not yet have engaged in care management and reach out to them accordingly. Please refer to **Figure I.C.24-11** below for a glimpse of what our pregnant Enrollees will see on their smartphone once they download the application and are engaged with Pacify.

Figure I.C.24-10
MyStrength Mobile App

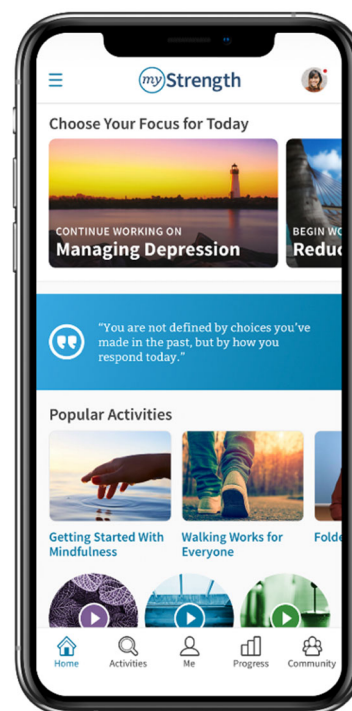
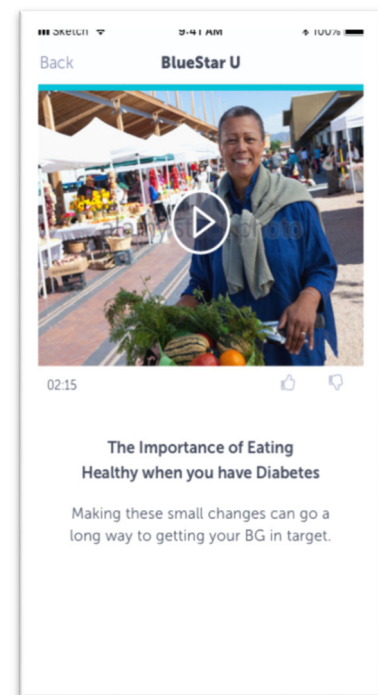


Figure I.C.24-11 Pacify Screenshot



WellDoc®: Humana is partnering with **WellDoc®** to introduce an innovative digital therapeutic application that has **proven successful at promoting better blood sugar control among 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, psycho-social factors such as stress, clinical symptoms, medication adherence, and lab results such as blood glucose levels. BlueStar gives feedback to Enrollees to promote self-management of critical behaviors such as diet and exercise and communicates lab results 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 health management dashboard. BlueStar has been demonstrated to contribute to significant reductions in A1C levels and has contributed to costs savings of 58% due to fewer inpatient hospital stays and ED visits. An example of WellDoc's interface is provided in **Figure I.C.24-12**.

Figure I.C.24-12
WellDoc Mobile App



Risk Tier 3: Intensive Care Management

Humana offers the same services to Enrollees in Health Promotion and Wellness and Management of Chronic Conditions to Enrollees enrolled in Intensive Care Management. In addition to the services described above, Humana provides the following core supports to Enrollees in Intensive Care Management:

- **Quarterly contact by their dedicated CM (at minimum) or more frequently to meet needs, in addition to face-to-face engagement (as needed or requested by the Enrollee)**
- Management of multiple chronic conditions that do not rise to the Complex Care Management risk tier

Risk Tier 4: Complex Care Management

Our Kentucky Medicaid population with the highest risk factors (multiple conditions/medications and those served by multiple systems), require higher levels of interventions and care to meet their complex clinical, behavioral, functional and/or social needs. Enrollees identified as needing Complex Care Management will have all the services and informational supports that are available to all other PHM Program risk tiers, tailored

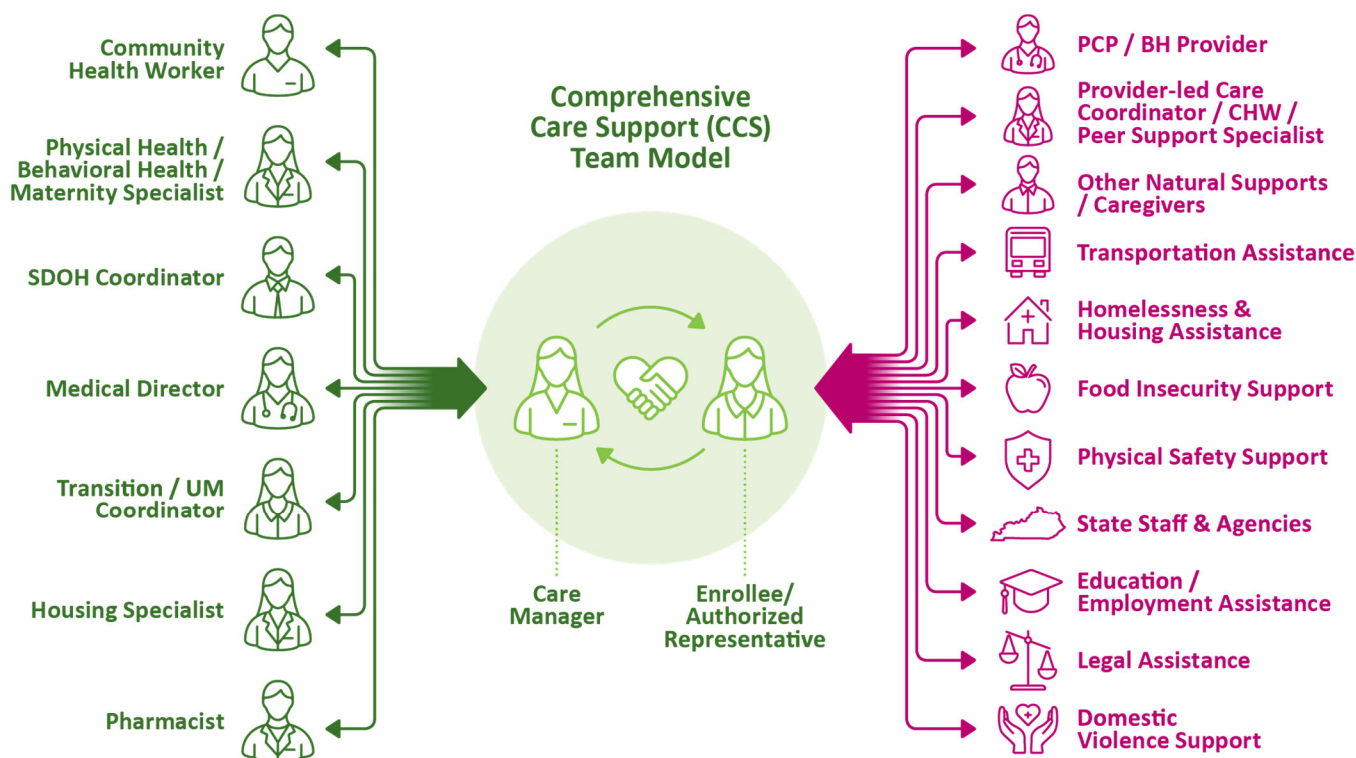
specifically to their needs and conditions. In addition, we will provide the following supports to Enrollees in Complex Care Management:

- **Monthly contact from their dedicated CM (at minimum) or more frequently to meet needs, in addition to face-to-face engagement (as needed or requested by the Enrollee)**
- Review of person-centered care plan and the Enrollee's current situation on a monthly basis (at a minimum)

Humana's Kentucky Medicaid Comprehensive Care Support (CCS) team

Comprised of Humana associates with expertise in physical health, BH, and SDOH needs of the Medicaid population, our fully integrated **Kentucky Medicaid CCS team** (as seen in **Figure I.C.24-13** below) anchors our Kentucky Medicaid care management program. On behalf of the Enrollee, this team serves as a forum to exchange information and ideas and ensure optimum outcomes. With the support and oversight of our **Kentucky Medicaid Medical Director, Lisa Galloway, MD**, subject matter experts within the CCS team are available for outreach by a CM to discuss any aspect of care and inform decision-making, taking the Enrollee's goals and preferences into account. In their role as the Enrollee's single point of contact for Humana support, our CM then brings this information back to the Enrollee for further discussion, to answer any questions, and to actively engage them as full participants in their health and well-being journey. This integrated model is an important mechanism to efficiently coordinate care and deliver services that meet the needs of our Enrollees with emerging risks and/or co-occurring, complex conditions. This structure also permits the Enrollee to remain with the same CM even if their needs change.

Figure I.C.24-13 Comprehensive Care Support (CCS) Team Model



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Description of the care planning process, including methods to ensure individualized and person-centered care plans, and summary of how the Contractor will include Enrollees, their caregivers, and multi-disciplinary teams.

CARE PLANNING PROCESS

Our care plan development process is **person-centered and Enrollee-driven**, with the care plan developed in conjunction with the Enrollee/legally authorized representative and other members of their chosen support system. Using the HRA, Enrollee Needs Assessment, and other data types and sources (as described in sub-question I.C.24.a.iv.b of this response) as its base, the care plan focuses on those services and supports that can help the Enrollee achieve their short- and long-term goals, strengthen self-determination, and move the Enrollee along the path to improved health and graduation from Humana's Kentucky Medicaid PHM Program risk tiers 2, 3, and 4 (when possible).



The care plan is comprehensive, including the Enrollee's physical health, BH, and SDOH services and needs. In addition, the CM has the flexibility to conduct additional assessments (see our response to I.C.24.a.iv.a for details) in response to the Enrollee's stated need to determine appropriate interventions. Our CMs complete the care plan in real time, in conjunction with the Enrollee and their support system, using CGX. Upon completion, the Enrollee and their representative can access the care plan via the Enrollee portal, with a printed copy provided upon request, while the Enrollee's providers (including their PCP and BH provider) can access the Enrollee's care plan via our provider portal, Availity. During subsequent care management contacts, we discuss the Enrollee's progress toward their goals, identifying any change in needs or services. We update care plans in compliance with the requirements in Section 34.3 PHM Program Tools of the Draft Medicaid Contract, including when the Enrollee's circumstances or needs change significantly; upon request of the Enrollee, their parent, or legal guardian; or upon request from a member of the MDT.

ENROLLEE ENGAGEMENT

The Enrollee is at the center of our Kentucky Medicaid PHM Program model of care. Humana's process emphasizes the Enrollee's involvement at every step, including the assessment and care planning process, and through each care management and MDT meeting. The Enrollee's lead CM (who may be their Humana Kentucky Medicaid CM or a provider-led care coordinator) gathers feedback on the Enrollee's care plan from their support system (to include caregivers), providers, CMs from State agencies and other plans, and other individuals identified by the Enrollee. We incorporate this feedback into the Enrollee's care plan.

Digital Platforms

Humana's Enrollee portal provides Enrollees with immediate access to their care plan including the crisis plan, claims, authorizations, and contact information for Humana. If an Enrollee in care management does not have a smartphone or does not have adequate data or minutes to stay engaged in care management (including the ability to contact their CM as needed and use the Enrollee portal), our CMs will help them access Humana's value-added services to receive a smartphone and/or unlimited minutes and data.

Culturally Competent Service Delivery

Recognizing the varied linguistic needs of Kentucky Medicaid Enrollees, including non-English speaking and non-verbal Enrollees, we take extra measures that account for their spoken languages and communication abilities. Our CMs have access to a variety of tools and resources to facilitate the assessment and care planning process for non-English speaking and non-verbal Enrollees. We assign Enrollees who are non-English speaking to a CM who speaks their preferred language, when possible. If this is not possible, our CMs will ensure an interpreter participates in all interactions. Translation or interpretation services include **more than 200 languages and American Sign Language (ASL)** in

More than **1,600**
Humana Kentucky
Medicaid Enrollees
are Spanish speakers.

person or via video. We conduct language tests for our bilingual associates to ensure proficiency and provide resources in the languages most prevalent across Kentucky's population, including Spanish, Chinese, German, Vietnamese, Arabic, and more.

For Enrollees who are visually or hearing impaired, we will use teletypewriter (TTY), braille, and other interventions to facilitate their full engagement in the care management process. In addition, Humana regularly translates care plans into other languages upon request. Our Concierge Service for Accessibility is available to help Enrollees and CMs arrange these services.

MULTIDISCIPLINARY TEAM (MDT) ENGAGEMENT

Reflecting our commitment to person-centered, holistic care management, Humana coordinates care with third-party resources who serve our Enrollees. **Humana CMs will invite third-party CMs to join our Enrollee's MDT, as appropriate and upon Enrollee request.** For example, Humana CMs will attend MDTs hosted by First Steps (upon invitation) and, conversely, invite First Steps CMs to join and contribute as part of the MDT process for First Steps-engaged Enrollees. Additionally, we will participate in any MDTs organized by third parties (as requested) to gain a full understanding of our Enrollee's needs and contribute our knowledge of the Enrollee's services received under Humana.

Humana has developed specialized processes that accommodate provider-led care management and reduce duplication with our own care management program. These processes (discussed in more detail in Section I.C.24.a.iv.m of the RFP response below) include:

1. Identifying providers and Commonwealth staff offering care management services
2. Establishing a communication process for care management inquiries
3. Identifying Enrollees receiving care management from a provider
4. Coordination of assessments and care planning
5. Participating in MDT meetings
6. Post-discharge planning

We will continue to develop our process for coordination with provider-led care management, including supporting providers to offer more care management services. This works hand in hand with our value-based purchasing approach, which we will continue to develop over the life of the Draft Medicaid Contract. We currently have an agreement with **KPCA** to provide a Per Member Per Month (PMPM) fee to support the delivery of care coordination by FQHCs. We are exploring to expand this agreement to CMHCs through an arrangement with **KARP, Inc.**, which represents 10 Kentucky CMHCs.

CAREGIVER ENGAGEMENT

At the heart of our care planning engagement process is a commitment to help people achieve their best health and lifelong well-being, and this includes involving Enrollee caregivers. We will therefore deliver specialized support to the caregivers of our Enrollees, with the aim of improving their well-being and reducing burnout. Our CMs will ensure all Caregivers (upon Enrollee consent) are involved in the development of person-centered care plans, to include their adequacy, involvement, and level of decision-making. This information guides the use of specialized resources available for not only our Enrollees but their caregivers as well. CM referrals for services available to eligible caregivers in our Kentucky Medicaid program include:

- **MyHumana's Caring for Others** site with resources and tips for caregivers to find the support they need to help their loved ones, including our **Caregiver's Toolkit**
- Department for Aging and Independent Living (DAIL)
- Area Agencies on Aging and Independent Living
- The National Family Caregiver Support Program
- The Kentucky Family Caregiver Program
- The Family Caregiver Alliance

- Humana’s Medical advice line and BH Crisis Line

We have also proposed including caregivers as members of our Quality and Member Access Committee (QMAC). Their participation on the QMAC will allow the opportunity for them to provide feedback on topics including care management, health education (including healthy living within the home and community), cultural competency, and quality and access. Our care management associates will be engaged in the selection of Enrollees and caregivers to serve on the QMAC, ensuring we can form a committee that is representative of our membership.



ASSOCIATE SPOTLIGHT:
Mary Harp, RN, Field Care Manager

Mary serves as one of Humana’s Kentucky Medicaid RN Field Care Managers. She has 13 years of experience in medical/surgical nursing, critical care, pain management, and Medicaid waiver program case management. Born in Japan to a Japanese mother and a father serving in the U.S. Air Force, Mary was inspired to become a nurse when her mother fell ill and required hospice care. She saw, firsthand, positive impacts hospice nurses made in such a difficult time and decided this too was her calling. Mary is excited to continue her passion of supporting caregivers and committed to improving the lives of our Enrollees and their families, caregivers, and other natural supports.

Adult Guardianship

For Enrollees under the oversight of adult guardianship, Humana will identify these individuals as ESHCNs using the guardianship indicator in the 834 enrollment file. With oversight provided by our **Kentucky Medicaid Guardianship Liaison, Elizabeth Emery, RN**, we will make every attempt to obtain the service plan completed by DAIL. The service plan will inform the need for care management and contribute to the development of an individualized Enrollee care plan. If a need is identified, Humana will collaborate with DAIL to determine the appropriate level of care management. We will comply with the requirement in Section 35.0 ESHCN of the Draft Medicaid Contract to send monthly reports to DMS 30 days after the end of each month.

At a minimum, Humana meets with DAIL staff monthly to identify, discuss, and resolve any healthcare issues and needs of the Enrollee as identified in the service plan, discovered through claims review or signaled by an increase in acute service utilization. Meeting attendees include Humana associates, administrative staff of DAIL, and DMS representatives. Ongoing calls with Regional DAIL supervisors also aid in the coordination and care of Enrollees. Humana maintains our responsibility for care coordination with DAIL regardless of the Enrollee’s participation in care management to ensure access to needed social, community, medical, and BH services.

We also maintain internal operating processes to ensure Enrollee’s access to care coordination and/or care management for all Enrollees served by DAIL. Humana tracks, analyzes, and reports on indicators that measure utilization, access, grievances and appeals, and services specific to the DAIL population.

Coordinating Care Management with State Staff

Humana works with each agency providing care management to our Enrollees to develop care management coordination procedures that are amenable to both parties. The assigned Humana liaison will take charge of developing these procedures, in coordination with the care management team. Each agency will be provided with a direct number to reach the CCS team, as well as a shared e-mail inbox to transmit information and send queries.

Upon identifying an Enrollee receiving care management from the Commonwealth, the Humana CM reaches out to the agency to identify the responsible CM (if given permission by the Enrollee), introduce themselves, and

discuss next steps, which includes the next MDT meeting. We invite Commonwealth CMs to join the Enrollee's MDT and share the care plan upon request. When the Enrollee has a state-developed care plan, we incorporate that information into the Enrollee's Humana care plan (with the Enrollee's permission). As with our network providers, we engage Commonwealth CMs in our discharge planning process to support the coordination of services, including follow-up appointments, and to reduce the number of contact points for our Enrollees.

Humana is an inaugural investor in **Unite Us**, a partnership with Metro United Way and other agencies to stand up and pilot a **digital care coordination platform that will facilitate and track referrals** between providers, care management, social workers, and the staff of CBOs as we collectively strive to coordinate and address

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Stakeholder engagement strategies, including involvement of community resources to meet social needs.

Humana prioritizes stakeholder engagement at every level of our operations: enterprise-wide, at a State level, and within the communities we serve. We have made an enterprise-wide commitment to population health, known as **Bold Goal**, with the goal of making significant reductions in Unhealthy Days as measured by the CDC. To accomplish this goal, our Bold Goal team in Kentucky has forged working relationships and partnerships with providers, community organizations, and business and government leaders. Since launching in 2015, the Louisville Bold Goal team has made meaningful investments in community initiatives. **Humana is a founding member and key facilitator of the Louisville Health Advisory Board**, a health collaboration comprising businesses, government, schools, and civic and nonprofit organizations. Through this organization, Humana has engaged the community and partnered with them to address key public health priorities such as diabetes, respiratory health, and barriers to care.

COMMITMENT TO COMMUNITY PARTNERS

Humana has a long history of community partnerships and engaging community partners across all of our lines of business. Driven by our Bold Goal team, we have developed significant and deep partnerships in Kentucky, particularly in the Louisville area. Our commitment to leveraging community partners is tied to our goal of meaningfully impacting social factors that adversely impact health outcomes and addressing ethnic and racial health disparities. These factors impact Medicaid Enrollees at a greater rate than other populations. Demonstrating this commitment, our Kentucky Medicaid leadership team will include several key staff positions dedicated to driving our population health model and community partnership goals:



- **Kentucky Medicaid Population Health Management Director, Adrienne McFadden, MD, JD**, who is in charge of our PHM programs (including care management)
- **Kentucky Medicaid Culture & Community Engagement Director, Bryan Kennedy**, who develops and supports our community partnership strategy
- **Kentucky Medicaid Community Engagement coordinators** who serve as direct liaisons to our community providers, supporting their missions, developing processes to link our Enrollees to their services, and identifying opportunities to support their service offerings.

Humana will also organize regional Community Advisory Boards (CAB) to serve as the eyes and ears of the community and identify gaps in services and areas of opportunity. These CABs will be attended by local nonprofits, CBOs, providers, Enrollees, Enrollee advocates, and others. The regional CABs will roll up to a statewide CAB, and their feedback will be incorporated into Humana's Quality Improvement Committee and governance process to inform opportunities for internal operational improvements and quality initiatives. The

Community Engagement team will work hand in hand with CHWs and SDOH coordinators in that region, along with the CCS team, to recruit Enrollees, organizations, and providers to the CAB.

EXPANDING CARE MANAGEMENT TO THE COMMUNITY

Humana's community-based outreach and education strategies reflect our commitment to meet Enrollees where they are with important health information. Humana's programs and processes are (by design) person-centered, recognizing that the most important stakeholder is the Enrollee. Our CCS team has several positions dedicated to linking Enrollees with community resources to meet social needs, including:

SDOH Coordinators

Humana will employ six SDOH coordinators. Regionally based, our coordinators are responsible for finding community-based support to meet Enrollee transportation, food insecurity, education, and employment needs, among other SDOH needs. Our SDOH coordinators will be responsible for supporting CMs and CHWs to find appropriate community resources to address SDOH. They will also serve as a resource for Enrollees not in care management to connect with needed SDOH-related services.

Housing Specialists

Humana will employ two Housing specialists with regional responsibilities. Recognizing the foundational role that housing plays in an Enrollee's health and well-being, Humana has designated a position to focus exclusively on helping Enrollees and their care team navigate the process of obtaining safe and affordable housing. Humana associates in this role will also be responsible for maintaining our Homelessness Outreach Plan.

Community Health Workers

CHWs are an integral part of Humana's CCS team. We employ five CHWs to serve our Kentucky Medicaid population today, and will employ 11 CHWs as part of our PHM model under the next Contract. These associates, positioned throughout the Commonwealth to ensure regional-specific coverage, will provide a range of supporting functions, such as setting and/or going to appointments, accompanying Enrollees to community resources, and providing education. Our CHWs support our CMs and play an important role in improving health outcomes and increasing Enrollee engagement. CHW responsibilities also include engaging our hardest-to-reach Enrollees. In line with those responsibilities and demonstrating Humana's commitment to meeting our Enrollees where they are, **we will engage with local organizations serving the homeless to determine the feasibility of allowing a Humana CHW to visit Enrollees onsite.** Figure I.C.24-14 illustrates the functions of our CHWs.

“
[Humana] has provided our clients with information sessions, one-on-one assistance, and group meetings. Kelli and her team are always there to answer questions from our caseworkers who are working each day to move our clients towards self-sufficiency.
”

– Carrie Thayer,
Director of Development,
The Hope House &
One Parent Scholar House

Figure I.C.24-14 CHW Functions

COMMUNITY HEALTH WORKER TOUCH POINTS



CHW CRITICAL FUNCTIONS

	Trusted advisor		Address SDOH needs
	Native to community		Link to CBOs
	Enrollee advocate		Partner with providers
	Administer HRA		Coordinate care

COMMUNITY ENGAGEMENT

Humana is expanding our community engagement function to better engage communities across the Commonwealth, creating a new position – our **Kentucky Medicaid Culture & Community Engagement Director**. Our Kentucky Medicaid Culture & Community Engagement Director, **Bryan Kennedy**, will report to our Kentucky Medicaid PHM Director, Adrienne McFadden, MD, JD, and oversee community engagement activities.

Community Engagement Coordinators

Community Engagement coordinators live in the regions they represent and are a critical on-the-ground resource to create meaningful partnerships. Their key responsibilities include:

- **Healthcare Navigation:** These coordinators help our community partners understand the Medicaid program and the services that are available to individuals they serve. These coordinators provide education and information and serve as a single point of contact for inquiries.
- **Expanding and Updating Humana's CRD:** Our coordinators update the CRD to include new information on community partners and maximize the accuracy of information within our CRD.
- **Engage with Community Partners:** Our coordinators serve as primary liaisons between Humana and our community partners. Examples include:
 - **Community Baby Showers** – In addition to participating in the State-sponsored community baby showers, Humana offers additional baby showers to Enrollees, providing education, resources, and other material support to assist families.
 - **Volunteer Management Initiative** – Humana has partnered with the Kentucky Nonprofit Network (KNN) to provide nonprofit organizations across the Commonwealth with quality, affordable, on-demand resources on volunteer management best practices.
 - **Targeted onsite education** – Multiple regions throughout Kentucky are at high risk for food insecurity, and our coordinators make a targeted effort to set up informational booths onsite at local food pantries in Regions 3 and 4 to create additional opportunities to connect Enrollees with services.

In 2019, Humana had an average of 17 Kentucky Medicaid Enrollees attend each of our Baby Showers.

Addressing Unmet Social Needs

Humana will continue to seek innovative ways to partner with community organizations to address unmet social needs for our Enrollees. In addition to the examples cited above, key partnerships currently under development include:



- **Food Insecurity:**
 - *Cooking Matters Program* – In partnership with **Share our Strength and Feeding Kentucky**, we will work with community partners to teach families basic cooking skills, how to budget, as well as how to utilize SNAP and WIC benefits.
 - *Feeding Kentucky* – We are exploring a pilot partnership to **distribute medically tailored food boxes via FQHCs**, working through the Kentucky Health Center Network. Providers receive training on screening for food insecurity as part of their broader screening efforts. Eligible patients are then able to receive prescriptions for a food box filled with healthy food items.
- **Combating Homelessness:** Comprehensive Care Management is a critical component to addressing unmet social needs that provides stabilization for Enrollees experiencing homelessness. Humana provides an innovative community-based approach to address homelessness with solutions that address individual needs. We seek to identify Enrollees who are currently experiencing homelessness or at risk for homelessness through 834 enrollment files by flagging Enrollees who have listed a homeless shelter as their address; during the completion of the HRA or Enrollee Needs Assessment; by mining of diagnosis codes and claims/encounter data, if submitted by providers; and through social needs assessments conducted by our community partners. Once identified, our CHWs will use **motivational interviewing techniques** to identify barriers to permanent housing solutions. Through a shared decision-making process, the CHWs and Housing specialists will promote responsibility and a sense of ownership as Enrollees work toward long-term housing. Humana understands that some Enrollees may be hesitant to identify as homeless and seek help or may not know how or where to find help. We have established partnerships with organizations that can help support Enrollees across the state, including **Volunteers of America Mid-States (VOA)**, **Legal Aid Society**, and **domestic violence shelters** across the Commonwealth. Partnerships with these organizations will increase the number of assessments and home placements able to be made by our CHWs. These community partnerships allow us to provide integrated, evidence-based intervention services such as Medical Respite and crisis stabilization support.
- **Workforce Development:** Humana recognizes that the health of our Enrollees is dependent upon their well-being and stability. Our voluntary, holistic workforce development program is designed to assist Enrollees find dignified, stable work that affords increased self-efficacy and self-sufficiency for themselves and their families. The **Humana Workforce Development Program** will provide up to 12 months of assistance to support each participant in planning for the future (e.g., education, training, financial counseling) and engaging in and maintaining meaningful work (e.g., job support and retention coaching). We will seek to build access to a **network of CBOs** with expertise in providing these services by rewarding those organizations who successfully place and stabilize employees. Additionally, we will connect Enrollees to resources across the community to address any unmet needs that present barriers to finding and retaining employment.
- **Dress for Success – Louisville:** To support our female Enrollees seeking employment, we are building a direct referral process with **Dress for Success – Louisville**, which serves job-seeking women through career mentoring, financial education, and the provision of professional career attire in the greater Louisville area.



Other Innovative Partnerships

- **Medical Respite:** An intervention and support designed to address the acute and post-acute medical care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to remain in a hospital. Research has shown **medical respite** programs to be effective in reducing subsequent ED visits and inpatient admissions and thus reduces hospital costs. Dedicated respite beds will be made available in VOA Southeast facilities equipped to house Enrollees in need, with tailored attention to the unique experiences of both individuals and families. Access to the medical respite bed and the critical wraparound services will be covered for a period of time that is deemed medically necessary. During this time, Humana CMs and VOA site managers will work together with Enrollees on next steps toward rapid rehousing or more permanent supports.
- **Crisis Stabilization:** Humana has partnered with **WellSpring**, a Kentucky-based provider of crisis stabilization, outpatient services, and supportive housing to individuals with SMI. This partnership will leverage WellSpring's expertise in the provision of these services to pilot an intensive and integrated wraparound service model targeting our Enrollees who chronically experience homelessness. Their mission will be to promote Enrollee independence, rehabilitation, community integration, and recovery, and in doing so, they will work to prevent homelessness, unnecessary hospitalizations, and other adverse outcomes. A key goal of the program will be to avoid chronic homelessness and prevent the Enrollee from returning to a shelter by stabilizing the Enrollee in a setting that is most appropriate for their medical and BH needs. WellSpring will collaborate with our Kentucky Medicaid care management team to provide the following services and supports to these identified Enrollees:
 - WellSpring care team includes a psychiatrist, nurse, social worker, Peer Support Specialists, a case manager specialized in services to the SMI population and brokering housing support, and an employment specialist
 - Available 24 hours a day, seven days a week, WellSpring will provide real-time support in a crisis situation to include an MDT for discharge planning support from the ED
 - Wraparound services from WellSpring include supportive housing, therapy services, transportation, medication management, group sessions, and crisis assistance
- **Diabetes Prevention Program:** Humana has partnered with the **KPCA** and the **YMCA** to pilot the CDC-recognized **Diabetes Prevention Program** at YMCA locations. In addition to the diabetes education and lifestyle change support, Enrollees who actively participate in the program receive up to a six-month YMCA membership for themselves, an additional adult, and their dependents under the age of 25



SPOTLIGHT ON REFUGEE HEALTH

CBOs play an essential role in helping our Enrollees who are refugees re-settle in Kentucky and engage with needed services. We therefore aim to work closely with these important stakeholders to ensure our Enrollees are receiving necessary supports, including healthcare that is attentive to their unique circumstances and backgrounds. In 2018, approximately 1,200 refugees entered the Commonwealth as part of the U.S. Refugee Program, according to the 2018 Kentucky Refugee Health Assessment Report. We currently partner with four CBOs across the Commonwealth to engage our **refugee population** where they are. Some examples of events we have participated in include:

- Participating in and sponsoring World Refugee Day for the past five years with the International Center of Kentucky in Bowling Green
- Sponsoring the World Refugee Day for the past five years in partnership with the Kentucky Refugee Ministries in Louisville
- Sponsoring the Kentucky Refugee and Immigrant Inclusion Summit in June 2019 in partnership with Kentucky Refugee Ministries in Lexington

We are also participating in a Health and Resource Fair this coming February 2020 in partnership with the International Center of Kentucky. Our cultural competency strategy for refugees contains three parts: 1) training, 2) community referrals, and 3) language services.

Leveraging local community organizations: We will also leverage our shared technology platform, **Unite Us**, to connect our refugee Enrollees with appropriate local organizations and services. Our closed loop referral system will enable our staff, providers, and community partners to 1) navigate on behalf of an Enrollee seeking assistance, 2) facilitate referral(s) to program(s), 3) track utilization of program(s), and 4) understand the impact of program participation on an individual's health.

a.iv.g. Technology and other methods for information exchange, as applicable.

Humana has made significant investments over the past few years to enhance our **clinical platform, CGX**. CGX's functionality enables direct and fully integrated management of physical health, BH, social, and pharmacological needs, enhancing our ability to:

- Document gaps in care
- Create integrated care plans that cover all aspects of an Enrollee's services and supports (including community resources)
- Automate alerts and referrals based upon predictive modeling and various algorithms to proactively address co-occurring needs and changes in condition

Figure I.C.24-15 below illustrates our clinical technology platform. This integration supports the efficient delivery and coordination of an Enrollee's services and supports. In addition, provider- or agency-created care plans can be uploaded and stored in CGX to complement the Enrollee's Humana-created care plan. The entire care team – from our CMs, CHWs, SDOH coordinators, and MSRs – has access to job-appropriate clinical information for an Enrollee and provides notification to other Humana associates when Enrollee education or assistance should be provided.

FIGURE I.C.24-15 HUMANA'S CLINICAL TECHNOLOGY PLATFORM

CLINICAL DATA

Humana integrates disparate data and workflows to create a robust operational and medical management infrastructure. This ensures real-time data sharing, connectivity with EHRs as applicable, the incorporation of predictive analytics, and multi-channel messaging. Key platforms and capabilities include:

- **Cotiviti:** **Cotiviti**, our clinical rules engine for external purposes, serves as the official source of truth for Humana's HEDIS results and HEDIS rate progress throughout the year. With each **monthly refresh** of HEDIS rates, HEDIS member-level detail tables are generated and sent to EDW where they are also used for operational progress reporting and clinical/quality analytics.
- **Anvita:** **Anvita** is Humana's internally managed clinical rules engine that allows us to generate care gap reporting on a more frequent basis in order to source Enrollee alerts, predictive models, and provider reporting on open care gaps and needed preventive services. It also supports our rapid-cycle quality improvement activities.
- **CareHub:** Our external and internal clinical data-sharing function allows Humana to share clinical data in real-time with our providers, Enrollees, and other partners. Data that are supplied through **CareHub** come from CGX, ATLAS, and EDW and consists of authorization inquiries, assessments, care plans, clinical alerts, clinical programs, health indicators, patient details, and patient summary. The Enrollee portal and provider portal (Availity) are two of the consumers of data transmitted by CareHub.
- **Health Information Exchange (HIE):** We use data obtained from direct connections built with almost all of the leading **EHR software systems (including Allscripts, eClinicalWorks, and athenahealth), as well as multiple state HIEs**, to gain insight into our Enrollees' provider interactions and capture information on Enrollee diagnoses, gaps in care, labs, medications, and needs that are traditionally available only through chart audits. Since 2014, Humana has been collaborating with 11 State HIEs to build ADT connectivity. Currently, we have six additional HIE builds underway, and our Health Information Technology team has been in conversations with the Kentucky Health Information Exchange (KHIE) regarding a path to connectivity.
- **Enrollee Portal:** Our secure Enrollee portal, **MyHumana**, gives Enrollees access to administrative and clinical information in an easy-to-use format. The portal allows Enrollees to verify eligibility, view demographics, request to change their PCP, and print and request ID cards. Clinical information available on the portal includes Enrollee history, referral history (including CM), PA requests/approvals/denials, Notices of Action, provider visits, vaccinations, prescription drugs, lab results, and care plans. Much of the information and many tools available on the Enrollee portal are also available on our MyHumana mobile app which is available for iOS and Android.
- **Blue Button:** Available on our Enrollee portal, MyHumana, **Blue Button** enables Enrollees to download their clinical claims history with one click. Giving Enrollees easy access to their data, Blue Button promotes care coordination, mobility, and transparency.



This transformative relationship [with Humana] brings together the provider, the payer, and the patient in new ways so they're all working from the same playbook. The relationship is also about aligning information to reduce the administrative burden on providers and improve quality and transparency for patients.

Alan Hutchison, Vice President
of Population Health, Epic®



Increasing providers' PHM capabilities requires access to accurate, actionable data. We have tailored our care models to meet providers where they are and support them with the tools they need to succeed. Using these tools, physician practices can continue focusing on prevention and improving health outcomes, quality, and cost while elevating the overall experience for their patients, physicians, and care staff.

AVAILITY

Humana's provider portal assists providers in their efforts to achieve optimal performance under VBP arrangements. Providers benefit from having a single location and consistent workflow to process transactions and securely access a wide range of financial, administrative, and clinical transactions. Availity offers the following features:

- The **practitioner assessment form** (PAF) is a comprehensive health assessment form physicians and other healthcare providers can use to help document vital patient information during a face-to-face physical examination. The PAF is a valuable tool to assist in closing care gaps through improved coordination of care.
- Availity's **Payer Spaces** allows Humana to securely deliver information to our providers. We have developed proprietary applications within Payer Spaces to partner effectively with our providers and share clinical information. Humana's Care Profile application enables providers to view attributed Enrollees' contact information, assessments, and care plans. Our Medical Record Management application enables seamless sharing of medical record information, including ADT data in near real time, between healthcare providers and our care management teams through our direct connection with EHRs.
- **Availity 360** supports providers in understanding their overall performance, supplying up to 12 months of aggregate information across a number of dimensions. We use reports from Availity 360 to evaluate transaction volumes; identify high utilizers; analyze error and denial trends; recognize patterns that may indicate fraud, waste, and abuse (FWA); and generate reports based on specific criteria (such as belonging to a disease registry).

COMPASS

Humana's proprietary Population Health Platform, Compass is a valuable tool for providers. Through our robust data-sharing capabilities, we are able to feed providers additional insight into their patient panel. These expanded population health data help our providers manage the health of their patients and to better inform their outreach and care. **Figure I.C.24-16** provides a screenshot of our Compass tool.

Compass compiles utilization, financial, and clinical data that can be filtered to enable providers to identify patients or groups requiring additional support. About a dozen core reports are included in Compass with additional reports available upon request. Captured below are the main types of reporting we share with our providers today:

- **Quality** reports identify HEDIS gaps in care as established by NCQA guidelines. They are an actionable breakdown of open gaps in care by Enrollee, with specific non-compliance reasons and suggested calls to action to aid providers in gap closure. Quality reports also include a detailed, comprehensive view of Humana Enrollees who suffer from diabetes, including testing for nephropathy, body mass index (BMI), and medication adherence. HEDIS gaps and analyses are updated weekly.
- **Pharmacy** reports include an actionable list of Enrollees who are at risk for non-compliance for medication adherence. In addition, these reports show percentage of days covered and list the actual pharmacy where Enrollees have their prescriptions filled. These reports also help to identify opportunities to improve adherence by highlighting opportunities to use mail order delivery or 90-day refills, when appropriate. Pharmacy savings and pharmacy coverage data are updated monthly.
- **Census** reports identify all attributed patients who are currently admitted into an inpatient care facility. They also identify Enrollees recently discharged from inpatient care. These analyses are updated daily.
- **Patient detail** reports provide an in-depth look at each Enrollee including demographics, visit history, diagnoses, HEDIS gaps, authorizations, physician visits, and clinical program participation.

Providers can access data and reports through the Compass platform at any time. Additional features of Compass include the ability to customize columns to accommodate the users' needs and desired views. Compass also has a new Key Performance Indicator (KPI) dashboard available to external provider access users.

Figure I.C.24-16 Compass Screenshot

Measure Name	Pass %	PYTD %	PFY %	Passing	Eligible	Open	Opp 5 Star	Star Level
HEDIS								
Adult BMI Assessment	98%	99%	99%	589	598	9	4	4 ★
Breast Cancer Screening	82%	82%	82%	217	262	45	1	4 ★
Colorectal Cancer Screening	86%	84%	84%	516	594	78	0	5 ★
Comprehensive Diabetes Care: Eye Exam	76%	67%	67%	146	192	46	4	4 ★
Comprehensive Diabetes Care: HbA1c Poor Control	64%	68%	68%	123	192	69	41	3 ★
Comprehensive Diabetes Care: HbA1c Testing	92%	90%	90%	178	192	14	-	-
Comprehensive Diabetes Care: Medical Attention for Nephropathy	94%	90%	90%	182	192	10	5	3 ★
Controlling High Blood Pressure	68%	-	-	416	604	188	-	-
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	92%	78%	78%	13	14	1	0	5 ★

a.iv.h. Frequency of provision of services

Humana tailors the frequency of services provided to Enrollees according to their risk tier. However, for each risk level, the contact may be more or less frequent as needed or requested by the Enrollee. Enrollees can contact Humana at any time for additional assistance through their assigned CM, CHW, an SDOH coordinator, or our call centers. Enrollees will also have regular opportunities and forums for interaction with our Community Engagement coordinators through community events. The overall goals, frequency of service provision, and criteria are summarized in **Table I.C.24-8**.

Table I.C.24-8 PHM Program Risk Tiers: Overall Goals, Frequency, and Criteria

Tier 1: Health Promotion and Wellness	Overall Goals:	Service & Frequency:	Criteria:
	<ul style="list-style-type: none"> Wellness and prevention support Enrollee empowerment for proactive participation in their own health and well-being Promote healthy lifestyle 	<ul style="list-style-type: none"> Annual outreach for HRA completion CM outreach upon notification of a change in condition, with reassessment as needed CHW support as indicated SDOH coordinators and Housing specialists as indicated Preventive care reminders Kentucky Medicaid Community Engagement team activities and events (ad hoc) Humana Neighborhood Locations open to all Enrollees and the public, offering onsite health, wellness, and social events, activities, and information during weekdays 	<ul style="list-style-type: none"> No/minimal risk factors identified No unplanned hospital admissions

<p>Tier 2: Management of Chronic Conditions</p>	<p>Overall Goals:</p> <ul style="list-style-type: none"> • Improve quality of life, self-management, and care integration • Address potential co-morbidities or other complications • Help to avoid complications • Prevent adverse outcomes • Reduce barriers to care • Reduce healthcare costs 	<p>Service & Frequency:</p> <ul style="list-style-type: none"> • All Tier 1 offerings • Bi-annual contact by a dedicated CM (at minimum) or more frequently to meet needs • Chronic condition management programs • Medication management • One-on-one health education (as needed and/or requested by the Enrollee) • Home health visits (upon medical and BH necessity) • Face-to-face engagement (as needed and/or requested by the Enrollee) • Virtual care management • Care coordination support from an assigned CM • CCS team support for CM, on behalf of the Enrollee • Access to remote monitoring platform • Assistance in coordinating with providers and State agencies • Personalized care plan 	<p>Criteria:</p> <ul style="list-style-type: none"> • Emerging risks factors and/or one targeted chronic condition • At rising or moderate risk for an inpatient admission, unnecessary ED visit, or institutionalization
<p>Tier 3: Intensive Care Management</p>	<p>Overall Goals:</p> <ul style="list-style-type: none"> • Improve quality of life, self-management, and care integration • Address co-morbidities and other complications • Prevent institutionalization • Help to avoid complications • Prevent adverse outcomes • Reduce barriers to care 	<p>Service & Frequency:</p> <ul style="list-style-type: none"> • All Tier 1 and Tier 2 offerings • Quarterly contact by a dedicated CM (at minimum) or more frequently to meet needs • Development of a transitional plan of care (when needed) 	<p>Criteria:</p> <ul style="list-style-type: none"> • Tier 3 exceeds contract requirements • Recent inpatient admission or potentially preventable ED visit within the past 90 days • Medical, BH, or health-related social needs that place them at risk for a readmission, unnecessary ED visit, or institutionalization

Tier 4: Complex Care Management	<p>Overall Goals:</p> <ul style="list-style-type: none"> • Improve quality of life, self-management, and care integration • Address co-morbidities and other complex complications • Prevent institutionalization • Help to avoid complications • Prevent adverse outcomes • Reduce barriers to care 	<p>Service & Frequency:</p> <ul style="list-style-type: none"> • All Tier 1, Tier 2, and Tier 3 offerings • Monthly contact by a dedicated CM (at minimum) or more frequently to meet needs • Review of person-centered care plan and current health/well-being status on a monthly basis (at minimum) 	<p>Criteria:</p> <ul style="list-style-type: none"> • Complex medical, BH, functional, and/or health-related social needs that place them at risk for a readmission, unnecessary ED visit, or institutionalization • High risk factors, including multiple conditions or multiple medications • Multiple, recent inpatient admissions or potentially preventable ED visits within the past 30 days
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a.iv.i. Priority areas (e.g., specific health risks, conditions, social determinants of health, etc.).

APPROACH TO IDENTIFYING POPULATION HEALTH PRIORITY AREAS

Data Analytics

Humana employs a data-driven approach to prioritize initiatives that will have the greatest impact on our Enrollees. Through our continuous quality improvement processes, we monitor the outcomes of our Enrollees on an ongoing basis and identify quality of care issues, care gaps, and health disparities in outcomes to identify priority areas, including specific health risks, conditions, and social determinants of health. As discussed earlier in our response to sub-question I.C.24.a.i, the following proprietary tools synthesize these metrics to identify characteristics and needs of the population:

- CDC Healthy Days Metric
- Humana’s Community Health Dashboard, Market Health Scorecard, and Social Risk Index
- zoom in™ SDOH Data Visualization Tool

Kentucky Thought Leaders

Partnering with State-based providers, public health agencies, academic institutions, and other community leaders, our goal is to discuss strategic interventions for a more person-centered, evidence-based care delivery system for our priority populations. Humana has partnered with the following organizations for targeted interventions with our Enrollees and individuals throughout Kentucky communities.

- CASA of the River Region: To further support children at risk of out-of-home placement and their families, the Humana Foundation has provided a grant of \$50,000 to CASA of the River Region. This grant will support CASA’s Giving Children Childhoods project, focused on expanding BH and ACEs screenings for engaged children, expanding access to an individualized, trauma-informed reading program, and establishing formal collaborations with addiction specialists to expand service delivery.
- UK HealthCare: We are excited to partner with University of Kentucky (UK) HealthCare, as their dedication to providing the most advanced, most effective care available – paired with their commitment to the pillars of academic healthcare (research, education, and clinical care) – supports Humana’s overall goal of improving population health outcomes. Further details on our unique collaboration with this Lexington-based partner can be found in the Humana – UK HealthCare Partnership callout box below.

Humana – UK HealthCare Partnership: Provider Training on Trauma-Informed Care

Humana will collaborate with UK HealthCare and the appropriate UK programs to support an initiative evaluating how informed provider groups are in secondary traumatic stress. In addition, this partnership will provide targeted educational seminars on topics identified as learning gaps, identify trauma-informed providers in our Provider Directory for Enrollee referrals, host conferences to inform key stakeholders of current issues and the latest research, and fund experts from UK to facilitate training on TIC and other relevant evidenced-based approaches.

“
The multiple strategies Humana is developing to address some of today’s most complex health and social problems, as well as their understanding of the issues at the local level, is impressive.

”
– Mark D. Birdwhistell,
Vice President for Health System
Administration & Chief of Staff,
UK HealthCare

- Louisville Health Advisory Board: Humana’s Bold Goal team in Louisville is exploring numerous opportunities to address priority needs and conditions that we have identified in our communities. The Bold Goal team is a key partner and facilitator of the Louisville Health Advisory Board, which has representatives from all parts of the community: businesses, government, schools, and civic and nonprofit organizations. LHAB convenes consumer discovery sessions, has held a Clinical Town Hall, and collects data to align on areas of focus to improve overall community health. Examples of initiatives informed by this process include:
 - Suicide Prevention: In addition to planning and facilitating three **Zero Suicide Community Action Planning Sessions**, the Louisville Health Advisory Board also set a world record for the most individuals trained in a single week in **Question, Persuade, Refer (QPR)**, an emergency response to someone in crisis.
 - Community Coordination of Care: LHAB launched the **Essential Needs Navigation Pilot with the Family Health Centers in Portland** (a community within Louisville, Kentucky) to address documentation of essential needs, use of the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (**PRAPARE**) **SDOH screening tool**, and follow up on documented needs with the service provider.

Enrollee and Provider Feedback

Humana also engages with a broad range of partners to collectively identify community priorities, and where opportunities exist, pilot initiatives to further our PHM goals. As discussed in our response to sub-question I.C.24.a.iv.f of this response, Humana is building upon the feedback we have received from our provider and Enrollee advisory groups to organize regional CABs. These CABs will create a forum for community partners to identify priorities and concerns and develop solutions for issues facing our communities.



ASSOCIATE SPOTLIGHT: Jessica Loar, CSW, BH Field Care Manager

Jessica serves as one of Humana’s Kentucky Medicaid BH Field Care Managers. She has 10 years’ experience in pediatric trauma and hospital case management, with previous roles as a Mental Health/SUD Social Worker and Medicaid Waiver Case Manager. With extensive experience caring for individuals with I/DD, including her brother, and those with autism, cerebral palsy, mitochondrial disorder, and other conditions, Jessica is passionate about improving the quality of life for our Enrollees with I/DD and their families.

PRIORITY POPULATIONS

Humana's priority areas align with the populations and conditions identified by the Commonwealth in Section 34.2 Conditions and Populations of the Draft Medicaid Contract. In addition to these key focus areas, Humana has identified the following:

- All pregnant women: As described above, we will aim to identify all pregnant Enrollees early in their pregnancies to encourage early and regular prenatal care and engagement in our MomsFirst care management program.
- At-risk/Imminent-risk children: We will identify children at risk for out-of-home placement using a pediatric version of the Enrollee Needs Assessment and by reviewing claims for Enrollees with SED, as they are likely to be at a higher risk for out-of-home placement. By identifying at-risk children earlier, Humana can leverage our care management processes to support the Commonwealth's implementation of the Family First Prevention Services Act and coordinate with providers of family reunification services, including KVC Kentucky and Centerstone. We have established partnerships with both KVC Kentucky and Centerstone to provide family supports and help our Enrollees remain safely in their homes.
- Persons who inject drugs: We will aim to build partnerships with organizations serving this vulnerable population to encourage referrals of Humana Enrollees for care management. These efforts will directly overlap with our Kentucky Medicaid Homeless Outreach Plan.
- Post-incarceration Population: Humana CHWs and Peer Support Specialists will play a key role in engaging our **post-incarceration population**. With the permission of the Enrollee, the CHW and provider-led Peer Support Specialist (upon assignment and with provider permission) will attend pre-release meetings alongside the CM if permitted by the correctional facility. We will make every attempt to conduct a face-to-face visit within a week of the Enrollee's release. This level of contact will enable the CHW and provider-led Peer Support Specialist to build a relationship with the Enrollee, support condition self-management, and encourage ongoing, meaningful engagement.
- Enrollees with extraordinary SDOH needs: We will identify Enrollees with complex or intensive SDOH needs that limit their ability to manage any chronic conditions or put their health at risk and engage them in one of our care management programs. These Enrollees receive focused support from the CM to address their SDOH needs, with the support of an SDOH coordinator and CHW (as indicated).
- Enrollees with limited access to care: Enrollees who are homebound, live in a rural area without access to transportation, or face other restrictions to accessing care will be targeted for support from an SDOH coordinator. We will aim to link these Enrollees with transportation assistance, mobile services, home services, or other options to resolve their barriers to receiving care. For example, **Humana will offer unlimited home health visits for high-risk pregnant women who face barriers to accessing care in office settings, including in-home administration of 17P injections for prevention of preterm births.**

PRIORITY CONDITIONS

Humana has processes and methods in place to appropriately identify Enrollees with priority conditions as listed in Section 34.2 Conditions and Populations of the Draft Medicaid Contract, including: **asthma, heart disease, diabetes, obesity, tobacco use, cancer, infant mortality, low birthweight, BH, SUD**, and other conditions determined by DMS. In addition to the priority conditions listed above, Humana will also consider the following conditions to be priorities among our Kentucky Medicaid membership:

- All pregnant women, in addition to Enrollees considered high-risk as determined by their providers
- Birth outcomes and NAS
- HIV/AIDS
- Hepatitis C

We will target these conditions through our PHM programs, including engaging Enrollees with the identified condition in one of our care management programs and facilitating community partnerships targeting prevention, detection, and support for individuals living with these conditions.

Supporting the Behavioral Health Needs of Enrollees who are Refugees

Our support for the Department's priority condition of behavioral health calls upon us to institute trainings and supports that address the BH needs of special populations. Recognizing the prevalence of BH disorders among refugees, including depression, anxiety, and SUD, we will offer our Enrollee-facing associates and providers a range of trainings aimed to better serve this population. These trainings include the following:

Training for Humana associates: **Humana will launch a specialized training on the needs of Kentucky's refugee communities** for our Enrollee-facing associates, including CHWs and CMs. This new training will focus on the specific health and social needs of our refugee population, as well as relevant cultural considerations, particularly in the areas of BH and domestic violence.

Trauma-Informed Care: Humana CMs and CHWs will also complete a specialized training on trauma-informed care through our partnership with the **Bounce Coalition**. This training will focus on the impact of Adverse Childhood Experiences (ACEs) and how to equip children with resiliency-building skills and coping mechanisms for dealing with trauma. Through both initial training and ongoing coaching, our CMs and CHWs will learn how to use communication techniques to gather critical information needed for the most appropriate level of care and engagement.

Training for Providers: Humana associates and our network providers can take additional trainings on trauma-informed care through our partnership with **Relias**. Relias' current course library for Humana associates and providers offers 343 trainings, including a course on helping children and adolescents cope with traumatic events and disasters.

PRIORITY SDOH AREAS

Housing

Humana has developed a comprehensive strategy to support the health of all Enrollees. We recognize that individuals experiencing homelessness and those who are at risk of homelessness face increased health and financial risks. Humana has created an approach to combatting homelessness by implementing evidence-based interventions and partnering with CBOs to sustain the work that is already being done. Our approach not only seeks to provide the critical services needed to assist individuals experiencing homelessness but also prioritizes services designed to prevent homelessness by addressing some of the systemic issues and individual challenges that push individuals and families into crisis. The following is our approach to engage homeless Enrollees:

- **IDENTIFY:** Proactively identify Enrollees who are homeless or at risk of being homeless
- **ASSESS:** Assess and understand the Enrollee and address the individual's needs
- **PARTNER:** Leverage partnerships with CBOs to provide resources to the Enrollee
- **STABILIZE:** Sustain support through tight integration with comprehensive care management and intensive care support
- **PREVENT:** Implement solutions to address the underlying needs of the population, including medical respite and eviction prevention and diversion solutions



Humana understands the importance of investing in solutions that tackle housing insecurity and other underlying challenges that lead to homelessness. Drawing upon experiences to date, Humana intends to initiate this investment with the launch of a focused eviction prevention pilot program in Louisville, as well as a medical respite pilot, both of which we intend to scale to other parts of the Commonwealth over time.

Eviction Prevention: Key to our strategy to serving our at-risk Enrollees is continuing to take steps with our community partners to prevent evictions in the first place. We will support the efforts underway at both VOA and Legal Aid Society to develop constructive relationships with developers and landlords and provide education and an avenue for early identification of at-risk Enrollees. At the same time, using the results of our HRA and the VI-SPADT, we can target services and supports to promote financial literacy and connect Enrollees to our **Humana Workforce Development Program**.

Eviction Diversion: In cases where eviction cannot be prevented, partnerships with VOA, **Legal Aid Society**, and other local community organizations will enable us to:

- Understand the underlying risks and issues that may lead or have led someone to potential eviction
- Develop a viable action plan with the Enrollee
- Negotiate with the housing authority and/or landlord on behalf of Enrollee
- Provide legal aid and support to individuals in need

Upon identification of housing insecurity risks, referrals will be made to VOA CMs. VOA has an existing relationship with the local **Housing Authority in Louisville**, as well as local landlords and housing developments, and a process in place to receive referrals directly from the Housing Authority for Enrollees at risk. Humana and VOA will work together to establish protocols for identifying healthcare needs that may be related to housing insecurity and ensure appropriate referral to, and coordination with, care management and health plan resources to provide support for critical health needs.

Medical Respite

Medical Respite is designed to address the acute and post-acute medical care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to remain in a hospital. Research has shown medical respite programs to be effective in reducing subsequent ED visits and inpatient admissions and thus reduces hospital costs. Dedicated respite beds will be made available in VOA facilities equipped to house Enrollees in need, with tailored attention to the unique experiences of both individuals and families. Access to the medical respite bed and the critical wraparound services will be covered for a period of time that is deemed medically necessary. During this time, Humana CMs and VOA site managers will work together with Enrollees on next steps toward rapid rehousing or more permanent supports.

Employment

Humana recognizes that the health of our Enrollees is dependent upon their well-being and stability. Our voluntary, holistic workforce development program is designed to help Enrollees find dignified, stable work that affords increased self-sufficiency for themselves and their families.



Program Overview

The **Humana Workforce Development Program** will provide up to 12 months of assistance to support each participant in planning for the future (e.g., education, training, financial counseling) and engaging in and maintaining meaningful work (e.g., job support and retention coaching). We will seek to build access to a network of CBOs with expertise in providing these services by rewarding those organizations that successfully place and stabilize employees. Additionally, we will connect Enrollees to resources across the community to address any unmet needs that present barriers to finding and retaining employment.

1. **Identifying Participants:** To identify Enrollees for the Humana Workforce Development Program, we will address SDOH needs and barriers identified through the HRA and other assessments. For those who express an interest and ability to work, we will provide detail on our voluntary workforce development program and make an appointment for an initial assessment with an SDOH coordinator. The SDOH coordinator will utilize assessment information to better understand the Enrollee's education, skills, goals, and barriers and refer them to a workforce development CBO.
2. **Career Coaching and Job Placement:** Workforce development-focused CBOs offer culturally competent expertise, an understanding of the needs of the people they serve (including Medicaid and related populations), and longstanding relationships with other valuable service agencies to identify and secure support services. For this reason, we envision building a statewide network of CBOs to connect Enrollees with comprehensive career coaching services to identify their strengths and goals, hone the skills needed to succeed in the workplace, and match them to appropriate job openings. Additionally, for those CBOs that have or can establish such services, they will provide job search assistance and job retention coaching.

As an example, Humana has developed a partnership with VOA Kentucky. The VOA approach uses supported employment specialists to work with program participants to provide job discovery, job search, job placement, and on-the-job support services. VOA brings more than five years of experience with this programming and a strong relationship with employers in Kentucky. Additionally, to support our female Enrollees seeking employment, we are building a referral process with **Dress for Success – Louisville**, serving women through career mentoring, financial education, and provision of professional career attire in the greater Louisville area.

3. **Removing Barriers and Providing Support Services:** Medicaid Enrollees and related populations cite a lack of transportation and unreliable or unaffordable child care as two common reasons for remaining unemployed. Support services that address life challenges and unmet needs are key to securing and maintaining a job. Our program will provide assistance, for the duration of the program, to remove these types of barriers to work. Program participants can call our SDOH coordinators, who will be trained to identify solutions for these barriers, or can work with their main point of contact at the CBO to identify and address these barriers.

Advancing Healthcare in Kentucky through Partnerships and VBP

Humana's approach to population health aims to strengthen the capacity and capabilities of existing CBOs (that provide services directly to Enrollees) and provide them with a sustainable rate for those services. Humana's Workforce Development Program is one component of our population health strategy whereby we will decrease barriers to achieving meaningful employment and increase overall self-efficacy and self-sufficiency. Humana will work with our CBO partners

The Humana Foundation is a strong supporter of community-based initiatives. **The Foundation's \$50,000 grant to the Big Brothers Big Sisters of Kentuckiana's School to Work program** is an example of a commitment that is particularly germane to workforce development and may offer potential future partnerships for Humana's Workforce Development Program.

School to Work provides high school students with valuable exposure to workplace skills and career opportunities. The collaborative program involves Big Brothers Big Sisters, high schools, and corporate partners. Corporate partners provide volunteer mentors, office meeting space, and expertise on topics covered during workplace visits. Monthly, students visit workplaces to meet one-on-one with mentors and participate in hands-on activities, presentations, and training sessions.

In 2018 and 2019, The Humana Foundation contributed \$1,075,000 to the Family Scholar House (FSH) for its HEROES program that builds upon FSH's current model of engaging low-income individuals to improve their overall well-being through education, career advancement, and family support services.

to design and collect metrics to track the success of our workforce development program and to understand the long term viability. These metrics will allow us to create a pay for performance relationship with organizations that are already in the community completing this valuable work and reward successful outcomes.

Education

Humana will offer reimbursement for tools that empower our Enrollees to get their GED. Humana Enrollees will have access to **GEDWorks™**, a program that includes the assignment of a bilingual advisor, access to guidance and study materials to prep for the tests, unlimited use of practice tests, and a test pass guarantee. The test pass guarantee ensures Enrollees can take the test multiple times (at no cost to the Enrollee) until they are able to pass. With the exception of the actual GED test, all other components are offered virtually, allowing maximum flexibility for our Enrollees to meet their goals.



Food Insecurity

We recognize that food insecurity can exacerbate chronic disease, complicate pregnancies, and lead to poor school performance, behavioral issues, and impaired growth and development. To combat food insecurity, Humana actively supports Enrollees' access to food security programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutritional Assistance Program (SNAP), and educate them on how to use these benefits at their local grocery store.



Humana also recognizes not all Enrollees qualify for these programs or may still require additional food supports. We are exploring numerous partnerships to respond to food insecurity within our communities, including the **Cooking Matters** program offering cooking classes focused on teaching families to plan and cook healthy meals based on a SNAP budget. Our partnership with Feeding America has also produced our **Food Insecurity Toolkit** that provides food insecurity resources for providers, CBOs, and government organizations. As an added benefit, we will offer **frozen delivered meals** to Enrollees who are engaged in transitional care management or who have a CM-identified food insecurity need.

Transportation

Humana provides educational materials regarding the availability of transportation services and refers Enrollees for NEMT. We stay in contact with the **Kentucky Transportation Cabinet's Office of Transportation Delivery** to ensure our eligible Enrollees receive safe and reliable transportation to Medicaid Covered Services. Our SDOH coordinators, CMs, CHWs, and MSRs are available to help our Enrollees learn how to submit a request for NEMT through the Office's procedures. Additionally, we direct Enrollees with other transportation barriers to public transport provided by the Kentucky Transportation Cabinet. This collaboration helps provide low-cost transportation services (based on county) to Medicaid Enrollees through the Cabinet's brokers.



If transportation is a major barrier for an Enrollee, Humana's **transportation benefit for three round trips per month** to places like the grocery store and community resources can be offered at the discretion of the Enrollee's CM or SDOH coordinator.

Physical Safety

We assess the physical safety of Enrollees to determine any resources or support needed. Members of Humana's Kentucky Medicaid CCS team have resources at their disposal to address the range of physical safety issues that can affect our Enrollees, including support for domestic violence, self-harm, child abuse, and natural disasters. In the event of a natural disaster, we leverage geographic data to identify Enrollees in flood and tornado evacuation zones and reach out to provide assistance. Our care management team can also help Enrollees develop a disaster plan, including where they can go in the event of a disaster and supplies to pack (e.g., prescription medications, potable water).



Childcare Assistance

Humana’s childcare benefit is available to Enrollees who are ready to seek employment and do not have the financial resources to cover childcare while interviewing or exploring employment opportunities. To assist, Eligible Enrollees can receive **up to \$40 per quarter to cover childcare**. We also help Enrollees arrange for proper childcare assistance through the **Division of Family Support’s Child Care Assistance Program**.

Legal assistance

For our Medicaid Enrollees who need legal assistance, Humana will provide education on benefits offered by the **Department for Income Support**. This agency provides assistance in applying for child support enforcement, and our SDOH coordinators, CHWs, and CMs are available to link Enrollees to community-based legal assistance, if desired.



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Description of staffing for each risk level, including staff to Enrollee ratios, modes of interface with Enrollees, and use of care managers.

STAFFING BY RISK LEVEL

Table I.C.24-9 summarizes staff-to-Enrollee ratios for those associates who serve Enrollees of all risk levels.

Table I.C.24-10 provides more detail on staffing by risk level and modes of interface, including our use of CMs to support our Kentucky Medicaid Enrollees.

Table I.C.24-9: Humana’s Kentucky Medicaid Staff-to-Enrollee Ratios

Applicable to Health Promotion and Wellness and All Risk Tiers	
Community Health Worker	1:25,000-30,000 Enrollees
SDOH Coordinator	1:25,000-30,000 Enrollees
Community Engagement Coordinator	1:15,000 Enrollees
Housing Specialist	1:75,000 Enrollees

Table I.C.24-10: Staffing, Modes of Interface, and Use of CMs by Risk Level

Risk Level	Staffing Ratios	Modes of Interface	Use of CM
Tier 1: Health Promotion and Wellness	Supported by CHWs, SDOH coordinators, MSRs, Community Engagement coordinators, and Housing Specialist; no ratios specific to this risk level	<ul style="list-style-type: none"> • Telephonic with MSRs, CHWs, and SDOH coordinators • Face-to-face, as needed, with CHWs and Community Engagement coordinators • Written and digital materials • Annual HRA completion 	Not assigned – see available supports within Tier 1 ‘Staffing Ratios’ within this Table I.C.24-11
Tier 2: Management of Chronic Conditions	1 CM:300 Enrollees	<ul style="list-style-type: none"> • Telephonic and face-to-face engagement (as needed) with CM, CHW; minimum bi-annually (more frequently as needed or requested) • Remote monitoring tools • Virtual care management 	Each Enrollee has an assigned CM, with support available from our CCS team
Tier 3: Intensive Care Management *Exceeds Contract requirement	1 CM:150 Enrollees	<ul style="list-style-type: none"> • Telephonic and face-to-face engagement (as needed) with CM, CHW; minimum quarterly (more frequently as needed or requested) • Remote monitoring tools • Virtual care management • Provider-led Peer Support Specialist (as requested and provider-approved) 	Each Enrollee has an assigned CM, with support available from our CCS team
Tier 4: Complex Care Management	1 CM:75 Enrollees	<ul style="list-style-type: none"> • Telephonic and face-to-face engagement (as needed) with CM, CHW; minimum monthly (more frequently as needed or requested) • Remote monitoring tools • Virtual care management • Provider-led Peer Support Specialist (as requested and provider-approved) 	Each Enrollee has an assigned CM, with support available from our CCS team
When a Kentucky Medicaid CM is assigned Enrollees from different PHM Program risk tiers, the CM’s caseload will represent a mixed ratio.			

Table I.C.24-11: Care Management Staffing Credentials

Population	Care Management Staff	Minimum Credentials
Complex Care Management	Care Managers	<ul style="list-style-type: none"> Registered Nurse (RN) Nurse Practitioner (NP) Clinically Licensed Behavioral Health Professional <ul style="list-style-type: none"> Licensed Certified Social Worker-Clinical (LCSW-C) Licensed Professional Clinical Counselor (LPCC) Licensed Marriage and Family Therapist (LMFT)
Pregnant Enrollees	MomsFirst Care Managers	<ul style="list-style-type: none"> RN or NP with OB/GYN experience preferred
Other ESHCN with Primary Medical Needs	Care Managers	<ul style="list-style-type: none"> RN, NP, or Physician's Assistant (PA) Master's Level Behavioral Health professional with certification or licensure [LCSW-C, Clinical Social Worker (CSW), LPCC, Licensed Professional Counselor Associate (LPCA), Licensed Clinical Alcohol and Drug Counselor (LCADC)]
Pediatric ESHCN, including Members Receiving Early Childhood Intervention (ECI)	Pediatric Care Managers	<ul style="list-style-type: none"> RN, NP, or PA Master's Level Behavioral Health professional with certification or licensure (LCSW-C, CSW, LPCC, LPCA, LCADC)
All other ESHCN with Primary BH Needs, including Serious and Persistent Mental Illness (SPMI)	Behavioral Health Care Managers	<ul style="list-style-type: none"> Professional Counselor Graduate degree in social work or related field Licensed Psychological Practitioner Licensed Psychological Associate

HOW COMMUNITY HEALTH WORKERS SERVE OUR ENROLLEES

CHWs are a critical element of Humana's staffing model and CCS team. We currently employ five CHWs to support Enrollees of all risk levels, implementing a regional hiring approach so our CHWs can serve Enrollees in the communities where they live. Details on our current Kentucky Medicaid CHWs can be found below, and we are excited to employ a total of 11 CHWs throughout the Bluegrass State upon Contract award.

- **America Gregory**, lives in Louisville, 23-year Kentucky resident
- **Cassidy Burke**, lives in Lexington, life-long Kentucky resident
- **Kelley Powell**, lives in Louisville, 48-year Kentucky resident
- **Tammy Dauley**, lives in Russellville, 36-year Kentucky resident
- **Tom Hall**, lives in Somerset, 55-year Kentucky resident

Our Kentucky CHWs are responsible for establishing and cultivating relationships with Enrollees and providers, connecting Enrollees with critical community support programs, providing Enrollee education, finding and connecting with UTC Enrollees, and helping Enrollees engage in care, including attending appointments with Enrollees as needed and requested. Humana hires CHWs from the communities they serve so they demonstrate strong sensibilities to locate and engage Enrollees in supportive care and provide culturally appropriate supports. They must have a close understanding of outreach strategies and the CBOs in their assigned region. Specifically, they:

- Perform feet-on-the-street functions to ensure HRA completion, targeting high-risk and UTC Enrollees
- Administer the HRA to identify Enrollee risks and SDOH needs
- Connect Enrollees to appropriate SDOH resources

- Improve engagement by building trusting relationships with Enrollees in a culturally competent manner
- Liaise among Humana CMs, providers, and CBOs to coordinate referrals for Enrollees to community-based services and programs and to foster integrated efforts among all parties
- Facilitate engagement between Enrollees and their PCP and encourage the completion of health promotion activities, including (but not limited to) HEDIS gaps in care

CHWs engage with social workers within the community to make referrals for community-based resources and help patients navigate these resources. Provider-based social workers leverage our CHWs to ensure Enrollees connect with the organization to which they have been referred. For instance, our CHW may accompany an Enrollee to a housing shelter or assist with finding a food pantry. Subsequent to a referral, a CHW may provide face-to-face follow up to ensure services are being provided or may visit an Enrollee's home to check on a utility assistance program set up by a CMHC-based social worker. Consistent and effective supports that improve Enrollee outcomes ensure network providers see our CHWs as valuable resources.

Like all Humana associates, CHWs undergo extensive initial, ongoing, and annual trainings conducted in person and through computer-based modules to prepare all associates to address the complex issues they may encounter. CHWs receive Humana-specific education and training on chronic conditions, BH conditions, behavior change theory, stages of change, and motivational interviewing. **Across the enterprise, all Humana associates, including CHWs, complete rigorous annual training courses that include health promotion, TIC, and cultural competency.** Cultural competency is an integral component of our culture at Humana, requiring associates who serve Medicaid Enrollees to complete supplementary training tailored to this population, including topics such as Health Literacy and Numeracy, Cross-Cultural Negotiation, and Understanding Seniors and People with Disabilities.

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If applicable, value-based payment (VBP) or incentive models the Contractor will include in Provider agreements to support involvement in the PHM Program.

For more than 30 years, Humana has been a leader in the establishment of Physician Incentive Plans (also referred to as VBP programs in this response) and was one of the first health plans nationwide to partner with providers in developing VBP models. We are focused on evolving our programs to promote continuous improvement through stronger clinical models that deliver high-quality, person-centered care to our Enrollees and stronger payment models that support our provider partners' practice transformation initiatives. **Today, Humana has more than 52,000 PCPs in value-based agreements across 43 states. In Kentucky, approximately 81% of our MA Enrollees are attributed to PCPs in value-based arrangements.** We have developed and plan to implement a VBP Strategic Plan in Kentucky that will deliver similar, if not higher, attribution results for our Medicaid Enrollees.

Humana understands that value-based care is essential to improving population health. We work closely with providers to transition their practices to an appropriate model based on the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) framework – with actionable data, care coordination, clinical programs, predictive modeling, and innovative solutions. The results of our experience developing and implementing VBP programs demonstrate improvement in care for chronic conditions, increased access to care, reduction in medical costs, and higher Enrollee satisfaction. Providers' success in our VBP programs depends on thoughtful incentives, consultative guidance, and care gap alerts that are integrated with and measured by comparative metrics and benchmarks.

We regularly analyze the performance of our VBP programs to identify best practices and opportunities for improvement. Recent analysis shows that Humana's VBP programs are improving quality and lowering costs. The results below illustrate the performance improvement of providers in Humana's Medicare Advantage (MA)

value-based arrangements across a variety of HEDIS measures, as compared to providers in our MA fee-for-service (FFS) arrangements.

Prevention	Utilization	Management & Adherence
 9% Eye Exams	 7% Emergency Department (ED) Visits	 11% Osteoporosis Management
 9% Colorectal Cancer Screenings	 5% Hospital Admissions	 2% Diabetes Medication Adherence
 9% Breast Cancer Screenings		 21% Blood Sugar Controlled

As part of our commitment to improve health outcomes through holistic care, we developed a VBP Strategic Plan that includes models to address all facets of Enrollees' determinants of health. All of our VBP programs include substantial incentives to drive practice transformation and compensate providers for associated costs. These programs are also designed to incentivize provider behavior that will drive positive health outcomes. We use flexible program design to meet providers where they are in VBP readiness and then support progress along a continuum of programs. To incentivize participation, Humana initially engages providers in upside-only arrangements with an easy-to-understand program design. To incent progress into more advanced VBP models, we offer larger financial incentives to providers at each level along the path toward full value. Humana plans to offer VBP models for the following provider types:

- PCPs
- BH Providers
- Maternity-focused VBP for OB/GYNs
- Specialists

Humana currently has more than 131,000 MA Enrollees attributed to Kentucky providers engaged in VBP programs. [REDACTED] As we implement VBP models under the Draft Medicaid Contract and work with providers to increase participation, we anticipate this figure will increase significantly.

Table I.C.24-12 provides an overview of our intended incentive plans for Kentucky Medicaid.

Table 1.C.24-12 Growing Value-Based Purchasing for Kentucky Medicaid

Provider Type	APM Level	Detail
PCPs	2. Rewards Only	<u>Medicaid Quality Recognition</u> : Bonus for meeting quality and outcomes metrics
	3. Shared Savings	<u>Model Practice</u> : Bonus payment for meeting quality and outcomes metrics *Potential for upside-only shared savings *Practice Transformation Incentive (PTI)
	3. Shared Savings	<u>Medical Home</u> : Bonus payment for meeting quality and outcomes metrics *Potential for upside-only shared savings *PTI *Monthly care coordination payment (or practices with NCQA PCMH Recognition)
	4. Full Risk	Monthly capitation payment (PMPM) or other risk arrangement that includes downside risk – providers have full responsibility for quality, outcomes, and cost

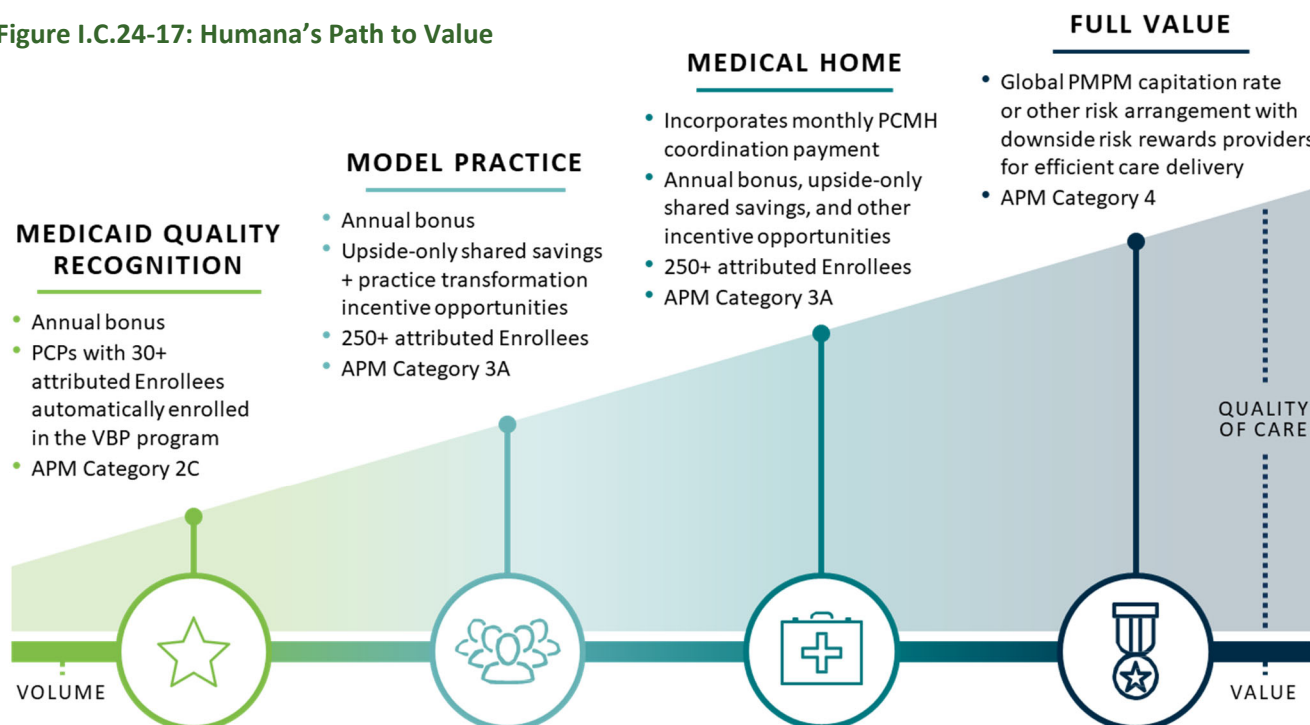
Table 1.C.24-12 Growing Value-Based Purchasing for Kentucky Medicaid

Provider Type	APM Level	Detail
OB/GYN	2. Rewards Only	<u>Maternity VBP</u> : A rewards-only bonus payment program for OB/GYNs for meeting quality and outcomes metrics
		*Bonus payment for meeting quality outcomes and metrics
		Notice of Pregnancy Incentive Program
	3. Shared Savings	Bundled Maternity Payments with quality metrics
	4. Full Risk	N/A
Behavioral Health (BH)	2. Rewards Only	BH Integration Referral Incentive
		Rapid Access Bonus
		BH Medical Home Incentive
	3. Shared Savings	<u>Bundled Payment</u> : Case rate for Medication-assisted Treatment
	4. Full Risk	N/A
Other Specialist	2. Rewards Only	N/A
	3. Shared Savings	<u>Bundled Payments</u> : Total Joint Replacement, Spine Surgery
	4. Full Risk	N/A
Additional Incentive Programs		
Extended Hours Bonus		

VALUE-BASED PROGRAMS FOR PCPS

The foundation of Humana’s Medicaid VBP strategy is our primary care-focused “Path to Value” continuum. Each step along the Path moves providers from volume-based payment toward value-based care. The Humana Path to Value maps to the HCP-LAN APM framework. This structure allows us to meet providers where they are in readiness for VBP arrangements, and we offer training and support that enables providers to progress into more advanced models.

Figure I.C.24-17: Humana's Path to Value



Medicaid Quality Recognition (MQR)

The first step on our Path to Value is the Medicaid Quality Recognition program. The MQR program incents provider behavior, such as screening for breast cancer and conducting annual wellness visits, by offering an annual bonus to PCPs meeting quality and outcomes goals across a set of predetermined metrics. Humana makes this first step into VBP accessible for providers by using eligibility requirements that will enable nearly all practices to participate. **We will automatically enroll all in-network practices with 30 or more attributed Enrollees and who are in good standing with Humana in the MQR, and they will become eligible to earn reward incentives.**

We measure practices according to metrics appropriate to the type of practice (e.g., adult, pediatric). The measure set includes access to care measures such as adult access to ambulatory and preventative care. Access measures are important because better care is strongly influenced by an Enrollee's relationship with a PCP. Inclusion of access measures increases PCPs' opportunity to meet targets and earn the bonus. We calculate and reimburse rewards on an annual basis.

Model Practice

The second step on the Path to Value is our Model Practice program. Model Practices assume greater accountability for managing patient care and therefore have the opportunity for greater rewards. The greater financial opportunity incentivizes providers to adjust their behavior and interventions, as necessary. PCPs meeting quality and outcomes goals across a set of predetermined metrics are eligible to receive an annual bonus payment as well as upside-only shared savings. In this program, practices are also eligible to receive a **PTI**, a payment for mutually agreed-upon practice infrastructure improvement investments, such as developing telehealth capabilities. A Humana Practice Innovation Advisor, a specialist on our Provider Relations Team, is available to advise providers on effective ways to invest the PTI into their practices. Practices become eligible to participate in the Model Practice program when they reach a minimum panel size of 250 attributed Enrollees. Providers are invited to participate in Model Practice following a formal assessment of the practice and its capacity to be successful in a shared savings model.

The Model Practice quality measures include HEDIS measures. Upside shared savings earnings reflect a practice's success in managing overall patient care, as measured by the avoidance of preventable hospitalizations and non-emergency use of the ED, for example. We make payments for achievements in the Model Practice program on an annual basis.

Providers in shared savings are inherently incentivized to consider the impact of SDOH on overall Enrollee health. If an Enrollee is experiencing food insecurity or homelessness, for example, they are much more likely to experience exacerbated physical and mental health issues. As a result, SDOH can lead to costly ED visits and hospitalizations that impact providers' shared savings. We offer providers trainings and tools to identify Enrollees with SDOH-related challenges and refer them to Humana CMs who will connect Enrollees with appropriate resources.

Humana is **exploring SDOH VBP pilot programs** with Kentucky-based provider partners to incentivize social needs screenings and referrals to community resources.



Expanding VBP to Medicaid – Provider Partnerships

Humana is committed to establishing the Path to Value programs in Kentucky Medicaid. We have obtained signed Letters of Intent (LOI) from **practices stating their interest in participating in Medicaid shared savings VBP programs**. In many cases, providers in our Kentucky Medicaid network are already in VBP arrangements for our Medicare line of business. Participating in our Medicaid VBP will be a natural extension for these providers.

Providers who have signed shared savings LOIs include Norton Healthcare, Lifepoint, Morehead Primary Care, UK HealthCare, Internal Medicine Associates of Frankfort, KentuckyOne, T.J. Samson Community Hospital, and Baptist Health System.

Medical Home

The third step on our Path to Value is the Medical Home program, which is available to practices that are recognized – or in the process of becoming recognized – as a PCMH and have a minimum panel size of 250 attributed Enrollees. These practices have taken steps to accept additional responsibilities as population health managers and are expected to progress toward and maintain PCMH certification. For example, Medical Home program participants support the integration of physical health, BH, and SDOH. Medical Homes often make other infrastructure changes that enhance the model of care, such as embedding care coordinators in their practice, adding telehealth technology, and using EHRs.

The Medical Home program is a shared savings model and has the same quality measures as the Model Practice program. Medical Home offers an additional PMPM care coordination fee to support more intensive patient management activities and to maintain PCMH recognition.

Full Value

The final step on Humana's Path to Value is the Full Value program. In this model, 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. Before entering into a Full Value contract, Humana conducts a thorough assessment of the practice and its capacity to be successful. We assess practices across more than 30 parameters organized into five categories: infrastructure, engagement with Humana, potential for growth, clinical operations, and financial operations. Practices in Full Value have demonstrated success in meeting quality metrics with the staffing, processes, and capabilities needed to manage all aspects of patient care. For example, Full Value practices employ social workers or care management associates and referral teams to engage Enrollees identified as UTC. These practices also use EHRs, are connected to the KHIE, and have a HEDIS team that manages care gaps and develops action plans to resolve those gaps.

To protect Full Value providers from excessive downside risk, Humana follows CMS's stop-loss protections as defined in 42 CFR § 422.208, which require that aggregate stop-loss protection cover 90% of the costs of referral services that exceed 25% of potential payments. Humana will risk-adjust provider payment rates to reflect the risk of the attributed population. Rather than waiting for potential payments from shared savings calculations after the end of the performance period, Full Value providers will have the option to obtain a portion of anticipated VBP payments prospectively based on interim financial and quality performance results.

Humana is raising the bar: Advancing VBP programs

Humana works with PCPs to determine the VBP arrangement that suits their current capabilities, experience, and readiness. We offer the necessary resources, including robust data analytics and touchpoints with Humana associates, to support the provider in progressing along the continuum. Humana has developed innovative VBP programs for other provider types to augment our PCP Path to Value continuum and improve outcomes for care provided in non-primary care settings.

VALUE-BASED PROGRAMS FOR BH PROVIDERS

Humana's VBP Strategic Plan supports the integration of physical and BH by embedding BH measures in PCP VBP programs. We also plan to offer several VBP programs that reward BH providers for improving quality performance and increasing access to BH services.

Rapid Access Program

Enrollees hospitalized for a BH-related illness are most vulnerable immediately following discharge from an inpatient stay or release from an ED visit. Timely follow up with a BH provider is critical to ensure Enrollees have an appropriate treatment plan in place and receive any necessary prescriptions in order to reduce the risk of re-hospitalization. To incentivize improvements in timely access to follow up care, [REDACTED]

[REDACTED] We will assess BH providers' abilities to deliver timely follow up care for the Rapid Access Program using the following three HEDIS measures:

- Follow-Up after ED Visit for Mental Illness
- Follow-Up after ED Visit for Alcohol and Other Drug Abuse or Dependence
- Follow-Up after Hospitalization for Mental Illness



Collaboration with CMHCs

We are in active discussions with **KARP, Inc.** regarding a proposal to pay a **PMPM care coordination fee** to its member CMHCs. The agreement to pay care coordination fees will give our BH providers the additional resources needed to support administration and care coordination tasks, including discharge planning for Enrollees with SMI. If successful, we will look to expand this model to our other network BH providers.

We will also explore the opportunity to provide a **bundled payment to CMHCs to support the provision of high fidelity wraparound services**. Via our communication with BH providers, we learned 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 delivery of wraparound supports to our child and adolescent Enrollees with BH needs. These wraparound services will be critical to the Commonwealth's adoption of the Family First Prevention Services Act, which will support families and promote permanency.

BH Integration Referral Incentive

Enrollees with BH needs, particularly those with SMI, often view their BH provider as their “medical home.” As a result, these Enrollees may not engage regularly or at all with PCPs who will focus on preventing and treating chronic physical health needs (e.g., well-care adult/adolescent visits, diabetes care, and weight management). To encourage and support integration of physical health with BH providers, Humana will incentivize BH providers to connect their patients into primary care.

Humana will continually solicit input from participating BH providers in the Rapid Access Program and/or BH Integration Referral Incentive to help refine each model, ensure meaningful incentives align with evidence-based care delivery, and engage more BH providers in advanced VBP arrangements.

BH Medical Home Incentive

Humana is implementing an innovative new model that supports BH practices in becoming medical homes, which promotes the integration of physical and behavioral health. Increasing ease of access to physical health services for Enrollees with BH diagnoses leads to overall improved health and well-being. 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., hiring 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 who 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.

Bundled Payments for MAT

Humana intends to implement a bundled payment program for MAT. MAT bundled payments cover the holistic care provided in opioid treatment programs, including medication management, group therapy, individual therapy, peer support, and care management. **This allows Enrollees to receive multiple services in a day without concerns about same-day billing or administrative code edit denials.** Bundled payments for MAT have the potential to improve outcomes and reduce administrative burden. We have partnered with several Kentucky BH providers, including Behavioral Health Group, Pinnacle, and Spero Health, to **develop bundled payment VBP programs** for MAT.

MATERNITY-FOCUSED VBP PROGRAMS TO IMPROVE BIRTH OUTCOMES

The infant mortality rate is 21% higher in Appalachian Kentucky than the national average and 10% higher than in non-Appalachian Kentucky.² Clinical strategies focused on prenatal care have been successful in reducing infant mortality. Incentivizing OB/GYN providers to improve performance on related quality measures will complement providers’ clinical strategies and improve birth outcomes in Kentucky.

Maternity Incentive Program

Humana’s Maternity Incentive Program measures OB/GYNs’ performance against critical measures that correlate with healthy births, including Timeliness of Prenatal Care and Postpartum Care. We have modeled the program after a successful VBP model in our Florida Medicaid plan, where we have improved birth outcomes through substantial incentives focused on prenatal and postpartum care.

² Appalachian Regional Commission, Fact Sheets: Health Disparities in Appalachia. August 2017.

https://www.arc.gov/images/appregion/fact_sheets/HealthDisparities2017/KYHealthDisparitiesKeyFindings8-17.pdf

Notice of Pregnancy Incentive Program

To improve prenatal care and engage Enrollees in our MomsFirst maternity care management program, Humana will offer an incentive for OB/GYN providers who submit a **“Notice of Pregnancy Form.”** [REDACTED]

VALUE-BASED PROGRAMS FOR SPECIALISTS

Humana plans to implement bundled payments for a range of specialty episodes of care. The applicability of payment bundles depends on an array of factors, including but not limited to, a practice’s overall volume and base payment rates. In addition to the MAT bundled payment program described above, Humana will also implement bundled payments for maternity, total joint replacement, and spine surgery.

EXTENDED HOURS BONUS FOR PCPS AND BH PROVIDERS

To improve access to care and accommodate Medicaid Enrollees’ schedules, Humana will offer an Extended Hours Bonus. [REDACTED]

We have **reduced ED visits by more than 12%** in 2018 in Florida as a result of extended office hours.

EXAMPLES OF SUCCESSFUL PHYSICIAN INCENTIVE PLANS

Humana has been developing incentive plans with providers for more than 30 years. Our experience in recent years has shown much success, not only in the level of engagement from providers but also in the health outcomes of our Enrollees. Here are a few examples of successful programs and value-based provider partnerships, including program structure, measurable outcomes, challenges, and lessons learned.

Florida Quality Bonus Program

Our Quality Bonus program offers our Florida Medicaid providers opportunities to be recognized for providing high quality care to our Enrollees. PCPs that exceed NCQA benchmarks across a series of HEDIS quality metrics related to access to primary care, immunizations, well-child visits, cancer screenings, and management of chronic conditions can receive bonuses twice a year. [REDACTED]

The bonuses offered through this program incentivize providers to implement interventions that improve HEDIS measures related to reducing preventable events. As providers assume no risk in this model, it serves as an introduction to VBP and prepares providers to move along the continuum toward more advanced arrangements.

The Quality Bonus VBP program has contributed to measurable success improving quality and health outcomes, including the following examples from 2017 to 2018.

- 9.24% increase in adults receiving BMI assessment
- 3.95% increase in breast cancer screenings
- 3.39% increase in cervical cancer screenings
- 2.48% increase in adolescent well-care visits

The challenges and lessons learned from the Quality Bonus Program have played an important role in designing our Kentucky Medicaid incentive plans. For a model like the Quality Bonus Program, where the incentives tie directly to specific HEDIS measures, carefully selecting program measures is critical. This lesson applies both in terms of which specific measures we select as well as the number of measures we select. If we select measures that do not apply to the provider type (e.g., pediatric measures for a PCP who only serves the adult population), providers will be frustrated by their inability to impact performance scores. In some cases, this may even lead to provider disengagement from the incentive program. Similarly, there are dozens of possible measures from which to choose; if we incentivize too many measures, providers may feel overwhelmed and disengage. Selecting a targeted, thoughtful list of measures will have a greater impact on provider engagement and quality

outcomes. We analyze results at the end of each year to make necessary adjustments and determine if different measures should be selected, based on feedback from the provider, State objectives, and Enrollee needs.

Another important challenge relates to the importance of accurate Enrollee data. For providers to improve performance, they depend upon accurate Enrollee contact information. Without it, providers are unable to close gaps in care, which negatively impacts quality performance, associated VBP incentives, and most importantly, health outcomes of Enrollees. We have developed programs to locate UTC Enrollees, update their contact information, and connect the Enrollees with their PCP. Efforts include visiting the Enrollee's home and community. These programs have targeted both adolescent and adult populations who have not seen their PCP in more than 12 months. By taking a direct role in locating UTC Enrollees, we hope to help providers establish relationships with their patients, resulting in better care for our Enrollees and the opportunity for providers to close gaps in care.

Pediatric Associates

In our Florida Statewide MMC program, we have a very strong and successful relationship with Pediatric Associates. Pediatric Associates is a provider in a full value, risk-bearing arrangement serving approximately 53,000 Humana Medicaid Enrollees. Pediatric Associates is Florida's largest privately-owned primary care pediatric practice with more than 200 providers and 32 locations. Humana has established a strong relationship with Pediatric Associates, through our VBP model, enabling us to collaborate on innovations to better serve our Enrollees.

Pediatric Associates has become one of our top-performing quality providers in Florida. They rank in the 94th percentile among similar contracted pediatric provider groups in Florida and rank first out of 20 Humana groups with a similar Medicaid pediatric population in Florida. Additionally, over a recent time period, we saw the following improvements:

- 4% improvement in annual dental visit rate
- 39% improvement in well-child visits in the first 15 months of life
- 10% ED visit reduction related to fevers

In 2018, our Florida Medicaid risk providers averaged **25.3% fewer ED visits per 1,000 Enrollees** and **17.4% fewer inpatient admissions per 1,000 Enrollees**, as compared to their non-risk peer group.

Our other Florida Medicaid risk providers have experienced similar successful health outcomes. Together, our Florida Medicaid risk providers averaged **25.3% fewer ED visits per 1,000 Enrollees** and **17.4% fewer inpatient admissions per 1,000 Enrollees**, as compared to their non-risk peer group in 2018. By reducing preventable events like these and helping Enrollees access care in appropriate settings, Florida risk providers also have **14.7% lower inpatient medical expenses** and **have reduced pharmacy expenses by 11.4%**.

In the years working with Pediatric Associates and other risk providers in Florida, we have learned valuable lessons from the challenges inherent to managing risk arrangements. One lesson relates to maximizing provider engagement. We have learned that if payment timing and payment amounts are not aligned appropriately with provider expectations, garnering interest and participation from providers can be difficult. Therefore, it is critical to design these program elements in collaboration with providers. Coordinating with providers creates a two-way forum where we can discuss important issues, such as each provider's Enrollee mix of the Medicaid population, and align on the financial aspects of the relationship accordingly.

Additionally, our experience with Pediatric Associates demonstrates the importance of sharing data and communicating clearly with providers as a means of increasing provider engagement and interest in the program. Maintaining meaningful contact with providers can be challenging, which is why we invested in a robust provider services organization in our Florida market. These Provider Relations representatives specialize in facilitating clear, useful communications and effective data sharing, which enhances provider participation

and generates actionable goals, leading to improved quality results. These lessons certainly apply in the Commonwealth of Kentucky and will greatly influence our efforts to build meaningful relationships with providers in the Kentucky communities we serve.

Norton Healthcare

Focused in the Louisville Metro area, Norton Healthcare is an integrated delivery system engaged in both full-risk and shared-savings arrangements with Humana MA plans. For these arrangements, Norton has 180 providers serving approximately 13,700 attributed Humana Enrollees across 33 PCP locations and five hospitals. Recent measurable outcomes demonstrate the value of Norton as a quality-oriented provider and the efficacy of our VBP arrangements with them.

- Overall improvement of Stars score: **2017 score of 4.14 improved to 4.61 in 2018**
- Reduction of inpatient admissions: **252 admits per 1,000 in 2017 decreased to 240 in 2018**
- Decrease in percentage of patients readmitted after discharge: **16.3% of patients were readmitted in 2017, which fell to 13.6% of patients in 2018**
- Improvement in the percentage of observation stays: **31.2% in 2017 improved to 34.3% in 2018**

Humana Provider Relations representatives work closely with Norton representatives to monitor the data behind these results and identify additional opportunities for improvement. The strategies and lessons from these discussions extend beyond the relationship with Norton and can apply, as appropriate, to other provider relationships in Kentucky.

Our longstanding relationship with Norton has developed over many years and evolved into a full value risk arrangement with Norton approximately three years ago. The success of this arrangement reflects Norton's dedication to quality improvement, and it also reflects the lessons Humana has learned regarding the need to offer a continuum of VBP programs and our support of providers' progression toward this type of advanced arrangement. This is why our Path to Value VBP continuum offers various levels of risk and reward, ranging from zero risk, rewards-only programs, to global risk opportunities. Our goal is to meet providers where they are with an appropriate VBP model for their current capabilities and then help them develop the infrastructure and resources necessary to be successful in more advanced risk arrangements.

Similarly, Humana has learned to invite providers to participate in full value risk arrangements only when they have a demonstrated track record of success. It is to the benefit of the Enrollees, providers, the Commonwealth, and Humana to ensure that providers are not exposed to undue downside risk if they are not ready. Even with stop-loss protections in place, downside risk arrangements may cause more harm than good if the provider is not sufficiently prepared. As such, assessing whether a provider is ready to move into a full-risk arrangement, then subsequently assisting them in this transition, must be a carefully-managed and monitored process.

This can also be a very challenging process because every provider is different and has different needs. Over the years, we have developed various training and education tools to help providers stay engaged with the VBP process and find answers to their questions. Our Provider Relations representatives meet regularly with providers and collaborate with them to set and achieve their goals. For example, if a provider group wants to improve their overall ED rate, the Provider Relations representative can provide valuable data and best practice recommendations to assist the group. In this manner, we are able to tailor the training and support that a provider receives depending on their needs and objectives.

“
Pediatric Associates has successfully partnered with Humana Medicaid for more than a decade. Our Full Value global risk arrangement has reduced administrative burden, and it helps us improve health outcomes for children on Medicaid. The combination of Humana's systems, data reporting tools, focus on population health, and dedicated provider relations team are far and away the best.
”

– Scott Farr, Chief Operating Officer,
Pediatric Associates

a.iv.i. Methods for evaluating success of services provided.

Humana monitors, tracks, and trends key indicators of clinical outcomes for our entire Medicaid population to evaluate, and subsequently refine, our programs and initiatives for success. Key metrics that inform this evaluation are:

- Clinical outcomes: Measured in numerous clinical and clinical quality measures, including HEDIS; select National Quality Forum (NQF) approved metrics; AHRQ Prevention Quality Indicators (PQI); and 3M PPEs, including potentially preventable admissions, potentially preventable readmissions, and potentially preventable ED visits.
- VBP Analytics and Forecasting: Humana's VBP Analytics team is dedicated to evaluating VBP results, with the purpose of making sure that we have the right program structure to influence behavior and health outcomes. The Analytics team compares the results, including financial, quality, and health outcomes, of providers in VBP arrangements against results for providers in FFS contracting arrangements. They compare provider performance across different VBP programs and track trends of providers' movement between the programs. At a more detailed level, the Analytics team assesses performance improvement across select measures to continually vet measure sets and associated benchmarks. They ensure VBP program incentives are recognizing providers for their work driving positive outcomes and not for random occurring events that would occur with or without a physician's intervention. These teams also help identify appropriate provider panel thresholds for different VBP programs, which can have a large impact on how performance is measured. They also inform the financial value of incentives by tracking costs and analyzing the value of closing gaps and meeting performance targets.
- VBP Program Evaluation: Monitoring VBP trends across the industry is an important way of evaluating our own VBP programs. Humana's corporate Provider Experience team presents at healthcare association meetings and attends conferences, providing opportunities to learn and share ideas about value-based care across the country. Their findings help us see where our programs may fall short, as well as where they are successful, relative to what they see and hear at these functions.
- External Reviewers: We also value the input of external feedback and data, which is why we seek insights from independent reviewers, such as physician associations and healthcare organizations. These reviewers help us understand how our VBP programs perform against industry trends and help us identify specific areas for improvement.
- Healthcare resource utilization and cost of care: Measured in ED per 1,000, admissions per 1,000, and 30-day readmission rate, as well as physical health, BH, and pharmacy costs.
- SDOH: Identifying and measuring SDOH such as food insecurity, homelessness, physical safety, employment, education, and transportation insecurity. Humana is currently working with NQF to develop quality measures for SDOH, including defining metrics for screening, interventions, and outcomes that we will pilot with provider partners.
- Enrollee Experience: Measured using Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction surveys

For Enrollees needing to manage their chronic conditions, we evaluate performance on a more condition-specific basis. The three key areas of focus are:

- Clinical Outcomes: We examine clinical metrics including pertinent HEDIS measures, PPEs, medication adherence, reduction in adverse events, and select measures that have a significant and demonstrable bearing on Enrollees engaged in our Management of Chronic Conditions program. We establish evidence-based targets for clinical outcomes measures, monitor and analyze trends and results, and make program improvements as needed. We identified positive changes in utilization among Enrollees with diabetes, asthma, and sickle cell disease (SCD) engaged in our Florida Managed Medical Assistance (MMA) care management program between 2017 and 2018. **Pediatric Enrollees with diabetes saw a 43% reduction in**

admissions; both adult and pediatric Enrollees with asthma achieved a more than 50% reduction in admissions; adult Enrollees with SCD saw a decrease in admissions of 30%; and Pediatric Enrollees with SCD saw a 40% reduction in admissions.

- **Enrollee Experience with Care Management:** In 2017 Humana conducted a survey to assess satisfaction among Enrollees who participated in the Humana Florida Medicaid care management program. **After participating in our care management programs, 95% of participating Enrollees said they were more prepared to manage their own health and were more likely to make a change in how they take care of their health.**
- **Program Savings:** We will analyze our data to better understand cost of care for Enrollees across PHM tiers, including evaluating changes in the medical PMPM for various conditions, evaluating preventable cost savings, and ensuring Enrollees continue to have access to high quality, medically necessary care to support health outcomes.

Humana uses a multi-faceted approach to evaluate the performance of our PHM Program and processes:

- **Quality monitoring:** We employ continuous quality improvement strategies, alongside rapid cycle improvement processes to monitor the quality of our PHM Program. We monitor, track, trend, and analyze key quality indicators that help us gauge its effectiveness, as well as help us identify gaps in care and areas where there are opportunities for improvement. These indicators include, but are not limited to: HEDIS, 3M PPEs measures, AHRQ measures, CMS Child Core Measures, and State-defined measures.
- **Identification of Health Disparities:** Humana deploys innovative tools and approaches to stratify Enrollees within health disparity variables to identify sub-populations, including evaluation of racial and ethnic disparities and identification of high-risk neighborhoods or geographic locations where health outcomes are disparate from the rest of the population.
- **Healthy Days Outcomes Stratification:** Humana analyzes Healthy Days data by lines of business; markets; chronic conditions, SDOH, and many demographic factors, including age, gender, race, and ethnicity. This allows for a deeper understanding of these populations and tailored interventions to address specific needs.
- **Humana's HEDIS Analysis:** Our HEDIS Data Analytics team identifies trends in HEDIS performance by race, ethnicity, gender, language spoken and geographic location that may indicate disparities in health outcomes.
- **GEOSCAPE:** We use GEOSCAPE's tool to view ethnicity, country of origin, and language data at the zip code level.
- **Enrollee satisfaction surveys:** A key avenue for ensuring ongoing engagement is to deliver a program that Enrollees find helpful and meaningful. Our satisfaction surveys conducted to date have found consistent improvements in satisfaction rates among our Enrollees engaged in care management. In addition, engaged Enrollees report that our program is helping them improve their health.
- **Quality of Life:** We employ the CDC HRQOL measure, Healthy Days, to assess both physical and mental unhealthy days. We use the Market Health Scorecard to help identify key performance indicators that correlate with Healthy Days and align initiatives accordingly.
- **ED utilization and inpatient hospitalization rates:** These are triggering events for engagement in the care management process and are also key metrics to assess healthcare resource utilization. We track changes in admits per 1,000 and ED visits per 1,000 to assess the impact of our care management program.

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Methods for communicating and coordinating with an Enrollee's primary care provider or other authorized providers about care plans and service needs.

Coordination with providers is key to our care management approach as we recognize that the PCP (or the primary practitioner from whom the Enrollee seeks care) is the treating and (often) trusted advisor for the

Enrollee. **Humana’s Kentucky provider network currently provides access to care for more than 900,000 Enrollees across all lines of business, and we are contracted with all FQHCs, CMHCs, and acute care and critical access hospitals. We have established relationships with 25,144 Kentucky Medicaid providers.** We recognize that many of our Enrollees with complex needs, including those with SMI, often have strong, established relationships with their care providers. Rather than disrupt these relationships with our own associates, we have designed our CM structure to incorporate and support existing care management services through robust data-sharing via our provider portal, Availity, and our PHM platform, Compass; seeking regular input from providers as part of the Enrollee’s MDT; and development of streamlined provider communication lines.

PROVIDER COMMUNICATION AND COORDINATION

Availity

Humana’s provider portal, Availity, supports our provider network in the day-to-day clinical care and financial management of the practice. Availity provides a single-stop, integrated platform for our providers to access information about their patient panel, submit claims and PA requests, and complete mandated and optional trainings. **In 2018, Humana network providers submitted more than eight million authorization and referral requests through Availity.**

Our provider portal, **Availity**, offers our providers in-depth information about the Enrollees under their care. This includes Enrollee care plans, assessments, claims, diagnoses, admissions, lab results, and information about the Enrollee’s additional coverage.

The Availity Care Profile platform provides a consolidated view of Enrollees and their healthcare services across providers. The Care Profile includes claims information associated with office visits and hospitalizations, diagnoses and associated procedures, prescription history, lab event history, radiology event history, immunization history, and clinical messaging, allowing PCPs and BH providers to gain a complete picture of their patients’ health care, including co-occurring diagnoses. Use of the Availity Care Profile can improve Enrollee safety, eliminate duplicate or unnecessary procedures, and improve coordination and continuity of care, including integration of physical health and BH services.

Population Insights Compass

Humana’s Population Insights Compass (Compass) is a valuable tool for our providers. Through the robust data-sharing capabilities enabled by Compass, we are able to provide additional insight into their patients and support targeted outreach, education, and integration of care for enrollees with co-occurring physical health and BH needs. We have designed Compass’s information-sharing mechanisms to comply with all applicable regulations guarding the privacy of our Enrollees’ BH information.

Compass compiles utilization, financial, and clinical data that can be filtered to enable providers to identify patients or groups requiring additional support or that have particular service needs. About a dozen core reports are included in Compass, with additional reports available upon request. These include:

- **Quality reports:** The quality reports contained in Compass identify HEDIS gaps in care, as established by NCQA guidelines. These reports provide an actionable breakdown of open gaps in care by Enrollee, with specific non-compliance reasons and suggested calls to action to aid providers in gap closure. In addition to alerting providers to gaps in care that they can close in their own practice, this information sharing encourages integration by alerting PCPs of BH gaps in care, and BH providers of physical health gaps in care: topics that they can discuss while the Enrollee is in their office and encourage them to take steps towards closure.
- **Pharmacy reports:** These reports include an actionable list of Enrollees who are at risk for non-compliance for medication adherence. In addition, these reports show percentage of days covered and list the actual pharmacy where Enrollees have their prescriptions filled. They also help to identify opportunities to improve adherence by encouraging mail-order delivery or 90-day refills, when appropriate. Pharmacy savings and pharmacy coverage data are updated monthly.

- Patient detail reports: These reports provide an in-depth view at each Enrollee, including demographics, visit history, diagnoses, HEDIS gaps in care, authorizations, provider visits, and clinical program participation.

DATA EXCHANGE THROUGH ELECTRONIC HEALTH RECORDS (EHR)

Humana **has direct connections built with almost all of the leading EHR software** systems including Epic®, Allscripts®, eClinicalWorks®, and athenahealth®, providing near real-time clinical data via continuity of care documents (CCD) from our network providers, as well as ADT notifications, if the vendor is capable. Humana works in partnership with EHRs and has made significant investments to enhance capabilities for data sharing between provider and payer, enhancing our providers' and Humana associates' ability to understand and respond to Enrollee service needs.



- Chart Retrieval: Humana receives encounter records for the purpose of health plan operations, either via a request/response process, or automatic feed based on payer identifier in the EHR.
- Hospital Notifications: Humana receives ADT notifications that allow Humana to know, in near real time, about the activity of Humana Enrollees in participating facilities. These notifications support care management processes as well as authorization management.
- IntelligentRx: Humana's proprietary **IntelligentRx** platform integrates with provider EHR systems to give prescribers immediate access to Enrollee-specific coverage information. When a provider enters a prescription or PA request with access to the IntelligentRx service, the system automatically reviews the Enrollee's pharmacy claims to assess possible adverse drug events and other safety concerns severe enough to deny a claim at point of sale. If an adverse event is identified, an alert is sent to the provider prior to writing the prescription, allowing the provider to select a safe formulary alternative.

Specialized Provider Processes

In addition, Humana has developed **specialized processes to accommodate provider-led care management** to reduce duplication with our own care management program. These processes include:

1. Identify providers and Commonwealth staff offering care management services: As part of their routine communications with our Medicaid providers, Humana Provider Relations representatives will determine provider capabilities in the area of care management, including the provider's employment of CHWs, care coordinators, or social workers; discuss specific care management services offered by providers; and identify a point of contact with the provider for all care management queries.
2. Establish a communication process for care management inquiries: Humana will provide a dedicated phone line and e-mail inbox for all care management inquiries. We staff the phone line during business hours, with call-backs within one business day for any messages left after hours. Our Provider Relations representatives, Provider Manual, and website share the details of the phone line and e-mail inbox for our providers.
3. Identify Enrollees receiving care management from a provider: As a routine part of our care management process, our CMs will contact the PCP and/or BH provider of assigned Enrollees to introduce themselves, educate them on the care management program, and invite them to join the Enrollee's MDT (as applicable). In addition, our CM will determine if the PCP and BH provider are providing care management services. If so, we note these services and point of contact on the Enrollee's care plan to enable ongoing coordination.
4. Coordination of assessments and care planning: While Humana will retain responsibility for completion of the Enrollee Needs Assessment and care plan, we will incorporate any provider-created care and treatment plans into the Enrollee's Humana care plan, with Enrollee permission, and will incorporate provider feedback on the care plan through the MDT (as described above). Our CMs will secure the provider attestation as required.
5. MDT meetings: If an Enrollee is receiving care management from their PCP or BH provider, we will support the provider as the lead CM on the MDT. During these meetings, we will review the Enrollee's care plan and

progress toward meeting goals, invite the provider of care management services to discuss how they are supporting the Enrollee, and discuss additional avenues for coordination and collaboration. Humana CMs will also join team meetings to which they are invited by the provider. Whenever possible, our CMs will aim to coordinate Humana MDT meetings with those hosted by the provider, including exploring options to combine team meetings.

6. **Post-discharge planning:** Our UM/Transition Coordinator will work closely with all providers, including the Enrollee's PCP and BH provider, to coordinate discharge planning for any Enrollee admitted to an inpatient or residential facility, regardless of their prior enrollment in care management. In addition to faxing admission and discharge information to providers serving Enrollees in care management, **we will place UM nurses onsite in high-volume facilities (with facility permission) to provide face-to-face discharge planning.** Our onsite nurse liaisons will work with our UM/Transition Coordinators, our BH UM associates, and CHWs to facilitate a smooth discharge and transition back into the community.

PROVIDER EDUCATION AND TRAINING

Humana offers our Kentucky Medicaid network providers access to **Relias' Provider Education eLearning Library**. This library currently offers 343 modules targeted at both physical and BH providers managing the care of Medicaid Enrollees. Most modules are accredited by at least one professional organization and are eligible for use for continuing education credits, building the capacity of our network PCPs to understand, screen for, and treat the BH needs most common in our Medicaid Enrollees. Utilization of these courses helps our network providers continue their education in specialty fields and enhance care delivery to meet Enrollee service needs. Sample Relias courses are listed in **Table I.C.24-13**.

Table I.C.24-13: Humana-Relias Provider Education eLearning Library Courses

Area	Sample Course Offerings
Integration	Integrating Primary Care with Behavioral Healthcare, Integrated Care Treatment Planning, Assessing Integration Readiness, A First Look at Integrated Care: Policy, A First Look at Integrated Care: Practice, Exploring Best Practice in Integrated Care, A First Look into Integrated Care for Primary Care Staff, Nutrition and Exercise for Clients in Behavioral Health
Screening and Treatment for BH conditions	Behavioral Health Screening Tools; Promoting Treatment Engagement with Behavioral Health Disorders; Bipolar and Related Disorders; Feeding and Eating Disorders: Diagnosis and Treatment; Diagnosis and Treatment of Personality Disorders; Post-Traumatic Stress Disorder; Interventions for Suicide Risk and Postvention for Suicide Loss Survivors; Community-Based Suicide Prevention; Suicide Risk Factors, Screening, and Assessment; Understanding Borderline Personality Disorder; Anxiety – GAD; Attachment Disorders: Attachment and Trauma; Diagnosis and Treatment of Depressive Disorders; Diagnosis and Treatment of Anxiety Disorders; Obsessive-Compulsive and Related Disorders: Diagnosis and Treatment; Supporting Recovery for Individuals with Schizophrenia
Telehealth	Telehealth in Clinical Practice; Ethical and Legal Guidelines for Telehealth; Best Practices for Delivering Telehealth; Implementation Guidelines for Telehealth Practitioners; Clinical Assessment via Telehealth Applications

Table I.C.24-13: Humana-Relias Provider Education eLearning Library Courses

Area	Sample Course Offerings
Substance Use Disorder	Overview of Substance Use Disorders; SBIRT: Intervention and Treatment Services for Individuals with Substance Use Issues; Biopsychosocial Model of Addiction; Confidentiality of Substance Use Treatment; Evidence-Based Practices in Treatment of Substance Use Disorders; Medication-Assisted Treatment for Opioid Addiction; Cultural Strategies for Relapse Prevention; Treatment Strategies for Relapse Prevention; The Twelve Steps; History and Evolution of Pain Management and Opioid Use in America; The Treatment of Chronic Pain; Clinical Practice Guidelines for Prescribing Opioids; Kratom: Herbal Supplements and Opioids; Treating the Opiate Epidemic; Substance Use in Women Across the Lifespan; Substance Use Disorder in the LGBTQ Community; Assessing Opioid Abuse in Families; Opioid Abuse in Adults; Core Competencies for Opioid Use Disorder; Harm Reduction; Family Therapy in Substance Use Treatment; Assessment and Treatment of Stimulant Use Disorders; Working with Court-Ordered Individuals in Substance Use Treatment; Substance Use and Risk of HIV, Hepatitis, and Other Infectious Diseases; Best Practices in Alcohol Use Disorder Assessment and Treatment; Marijuana and Cannabinoids, Pain and the Brain; Connecting Substance Use and Interpersonal Violence
Children and Adolescents	Adolescent Substance Use Disorder Clinical Pathways; Prevention of Substance Use for Transitional-Aged Youth; Treatment of Opioid Dependence Among Adolescents and Young Adults; From Prescription Opioid Abuse to Heroin Use in Youth and Young Adults; ADHD: Etiology, Diagnostics, and Treatments; Behavior Management in Early Childhood; Fundamentals of Fetal Alcohol Spectrum Disorders; Helping Children and Adolescents Cope with Violence and Disasters; Assessment and Treatment of Anxiety in Children and Adolescents; The Impact of Parental Substance Use Disorders; Traumatic Stress Disorders in Children and Adolescents; Non-Suicidal Self-Injury in Children, Adolescents, and Young Adults
Older Adults	A Day in the Life of Henry: A Dementia Experience; Screening, Brief Intervention, and Referral to Treatment of Older Adults with Opioid SUD; Alzheimer's Disease; Developmental Milestones and Mental Health Issues in Older Adults; Treating Substance Use Disorders in Older Adults; Depression in Older Adults; Challenging Behaviors of Older Adults with Dementia; Depression in Older Adults
Individuals with Intellectual and Developmental Disabilities (I/DD)	Abuse and Neglect of Individuals with I/DD; Intellectual Disability Overview; Medication Management for Individuals with Developmental Disabilities Part 1; Supporting Quality of Life for a Person with Developmental Disabilities; Intellectual Disability Part 1: Understanding the Construct and Its Assessment; Intellectual Disability Part 2: Assessing Intellectual Functioning and Adaptive Behavior; Intellectual Disability Part 3: Diagnosing Intellectual Disability and Planning for Supports; Strategies for Socialization and Integration for People with Autism Spectrum Disorder; Ways to Support People with Autism Spectrum Disorder
Co-Occurring Disorders	Integrated Treatment for Co-Occurring Disorders, Serious Mental Illness and Respiratory Disease, Cardiovascular Disease and Behavioral Health Disorders, Addressing Mental Health Concerns in Patients with Cardiovascular Disease, Addressing Mental Health Concerns in Patients with Diabetes, Managing Medicaid Members with Chronic Behavioral and Physical Health Conditions

Table I.C.24-13: Humana-Relias Provider Education eLearning Library Courses

Area	Sample Course Offerings
Trauma-Informed Care	Does Your Organization Measure Up: Are You Really Trauma-Informed?; Trauma and Substance Use; Attachment Disorders: Attachment and Trauma; Trauma-Informed Clinical Best Practices: Implications for the Clinical and Peer Work Force; Compassion Fatigue and Satisfaction; Helping Children and Adolescents Cope with Violence and Disasters; Internalizing Disorders: A Focus on Anxiety and Related Disorders in Children and Adolescents; Introduction to Trauma-Informed Care; Mitigating the Impact of Disasters: From Trauma to Resilience; Overview of Trauma Disorders in Adults for Paraprofessionals; Trauma and Stressor Related Disorders in Children and Adolescents; Traumatic Stress Disorders in Children and Adolescents; Post-Traumatic Stress Disorder; What Does Becoming Trauma-Informed Mean for Non-Clinical Staff; Calming Children in Crisis; Trauma Informed Treatment for Children with Challenging Behaviors; Implementation of Trauma-Informed Care Systems; Compassion Fatigue, Secondary Trauma and the Importance of Self Care; Trauma-Informed Supervision; Disaster Trauma: Promoting Resilient Individuals, Organizations, and Communities
Courses for Paraprofessionals	Understanding ADHD; Medication Management for Children’s Services; Overview of Autism Spectrum Disorder; Overview of Psychiatric Medications; Overview of Serious Mental Illness; Overview of Trauma Disorders in Adults
Psychopharmacology	Overview of Psychopharmacology; Benzodiazepines: Uses, Misuses, and Treatment
Caring for Veterans	Veterans Suicide Prevention and Intervention; Identification, Prevention, and Treatment of Suicidal Behavior for Service Members and Veterans; Common Mental Health Conditions in Veterans; Addressing Substance Use in Military and Veteran Populations

Psychiatric consultation service

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 capacity, including systematic and evidence-based screenings, and treatment for mild or moderate BH conditions (including medication management, as appropriate), without further referral.

SDOH provider education

Humana works with our providers to address SDOH-related social needs at the local level. Knowing physicians and clinicians our often our Enrollees’ most trusted source for care, we equip our providers with screening tools and educational materials that care for the whole person – both inside and outside of the clinical setting. In addition to our **zoom in™ SDOH visualization tool** (for details, please see our response in sub-question I.C.24.a.i), we offer resources such as a Food Insecurity Toolkit and Food Insecurity Quick Guide (see **Attachment I.C.24-1 Physician Quick Guide to Addressing Food Insecurity**) to support provider delivery of care management supports. These informational documents can be accessed online at populationhealth.humana.com.

Figure I.C.24-18 Humana's Population Health Website Screenshot



EPSDT and EPSDT Special Services

To inform our providers on EPSDT and EPSDT Special Services, we have produced a Kentucky Medicaid Provider Toolkit. This toolkit is an educational, well-child visits reference guide that outlines the preventive and special services covered under the EPSDT program, the EPSDT exam frequency, Kentucky-specific requirements, billing tips, referral codes, and other references. The toolkit will be made available to our providers via our public website. Please see **Attachment I.C.24-2 Kentucky Medicaid EPSDT Provider Toolkit** at the end of our response

for a copy of this toolkit.

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Role, if any, the Kentucky Health Information Exchange (KHIE) will play in the Contractor's PHM Program as a resource.

KENTUCKY HEALTH INFORMATION EXCHANGE (KHIE)

KHIE will advance our PHM strategy by increasing the number of connected providers and the volume of transactions transmitted through health information exchange (HIE). Having more providers and data flowing through KHIE increases the likelihood of care coordination, event notification, and care gap closures – activities at the core of our PHM strategy. A secondary benefit of broadening and deepening connectivity to KHIE is the opportunity to expand providers' understanding of their patients' needs, leading to appropriate segmentation of populations according to risk and targeted outreach aimed at specific high need population groups. For example, in our Florida Medicaid program, we have used ADT data from the HIE to develop predictive models identifying the likelihood of emergency room visits for Enrollees with certain characteristics and use patterns; we have used this information to reach out to Enrollees to establish primary care homes.

As a national health plan and an industry leader in interoperability, our goal is to facilitate data sharing by collaborating at national, State, and provider levels to reduce provider abrasion and increase the quality of care for our Enrollees. To advance interoperability in the industry, we work alongside government agencies and Information Technology (IT) vendors to create national data standards that allow for accelerated and seamless information sharing. By partnering with states and their respective HIEs, we support the vision of statewide interoperability. Since 2014, Humana has been collaborating with 11 State HIEs to build ADT connectivity. Currently, we have six additional HIE builds underway, and our Health Information Technology team has been in conversations with KHIE regarding a path to connectivity. From October 2018 to September 2019, Humana experienced more than 40.6 million transactions with EHR vendors and HIEs on behalf of providers located in Kentucky, the remaining 49 states, and the District of Columbia.



We are addressing providers' barriers to EHR adoption and HIE usage with both technical and financial support. **Humana is committed to investing \$500,000 to increase connectivity to KHIE and promote EHR adoption.** These funds will be targeted to providers demonstrating the highest need with a particular emphasis on providers in high need communities (such as isolated, rural areas) and those offering BH services. We seek to partner with Regional Extension Centers (REC) to ensure these funds are leveraged to assist providers demonstrating the greatest need. We are enhancing our understanding of provider connectivity by collecting EHR information when providers are brought on board and during quarterly site visits. We will work with KHIE to understand which providers are connected and develop outreach efforts to non-connected providers.

Members of the Provider Relations Team will assist eligible providers in applying for awards from the fund. In the course of their routine site visits, the team will certify that those providers in receipt of awards are using the funds for the intended purpose and assist with any EHR issues the provider is experiencing. Humana representatives will also promote the use of Humana's proprietary provider performance management platforms Availity and Compass, which Humana has developed to transmit and display information concerning care received by Enrollees. These platforms assist providers in key areas: Availity eases administrative burden through streamlined PA and claims submission and management, while Compass guides providers through quality improvement opportunities. We will offer training and technical assistance to providers and their staff who need assistance in using these platforms.



We have developed a multi-part campaign to encourage or induce providers to connect with KHIE. Key parts of the campaign include:

- Offering financial assistance to high need providers lacking KHIE connectivity
- Ensuring providers are sending immunization records to the Kentucky Immunization Registry via KHIE
- Conducting education campaign on KHIE in collaboration with RECs
- Liaising with EHR vendors to assist with KHIE connectivity
- Ensuring Participation Agreements are in place for those with no KHIE connectivity
- Requiring hospitals to have KHIE connectivity through their contract with Humana
- Offering financial incentives to certain small, rural providers and hospitals to connect with KHIE
- Promoting hospital connectivity to KHIE
- Collaborating with other MCOs and KHIE to establish MCO connectivity to KHIE

We believe that there is an opportunity to improve the accuracy of immunization data held in the Kentucky Immunization Registry (KYIR). We are in the process of working with KYIR to allow immunization data to flow into Humana systems. We then will be able to match that information against claims history and clinical information in Humana's EDW. Humana will report data to the Kentucky Immunization Registry to support the accuracy of data in the Registry as a whole. Humana is entering into a Business Associate Agreement with the Kentucky Immunization Registry to allow for this data connectivity.

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Provide the Contractor's proposed approach to coordination with other authorized providers such as the WIC program and others.

COORDINATION WITH AUTHORIZED PROVIDERS

Special Supplemental Nutrition Program for the WIC Program

Humana coordinates with the **WIC program** to ensure that pregnant women and children up to the age of five are aware of and connected to this resource. We coordinate with WIC by:

- Including information about the program and how to apply for the program in the Enrollee Handbook
- Including information about the program in our provider training to ensure that eligible Enrollees are aware of this resource

Humana refers potentially eligible women, infants, and children to the WIC program, with the support of our Kentucky Medicaid CHWs and SDOH coordinators to help bridge these connections and provide Enrollee guidance. We will use the HRA and Enrollee Needs Assessment results to identify individuals with food insecurity and refer them to WIC, if appropriate. Additionally, through routine MomsFirst and NICU care management contacts, Humana associates will initiate and follow up on WIC referrals to ensure that needed services have been provided. We coordinate the provision of medical information, as requested by WIC and in compliance with applicable law.



ASSOCIATE SPOTLIGHT:
Jackie Baker, RN, Field Care Manager
MomsFirst Program

Jackie serves as one of Humana's Kentucky Medicaid MomsFirst CMs. She has 25 years' experience in maternal-infant clinical settings, starting in labor and delivery and moving to postpartum and antepartum care. Her previous roles include contraceptive and HIV counseling for the Women's Health Clinic at a local Family Health Center, Director of Nursing at a local Community Health Center, and Medicaid Director of Maternal-Child Health Programs for a health plan. Jackie is passionate about delivering holistic and individualized care to our perinatal Enrollees and excited for the opportunity to improve outcomes for high-risk pregnant women, infant mortality, and NAS in the Commonwealth.

Coordination with other providers

In addition to WIC, Humana will partner with other programs providing non-covered and carved-out services to our Enrollees, including the **Kentucky Health Access Nurturing Development Services (HANDS); First Steps; School-Based Services; and the Kentucky Transportation Cabinet, Office of Transportation Delivery**. We identify Enrollees who may benefit from these services through the HRA, Enrollee Needs Assessment, and ongoing care management activities. In addition, we will train our MSRs on these programs and associated referral procedures to assist inbound callers.

Head Start

Our CMs work with our Enrollees and their caregivers to facilitate a referral to Head Start (as needed). We note Head Start services on the Enrollee's care plan, and our CMs follow up on Head Start referrals during their routine contacts with Enrollees to ensure they were connected with the appropriate services. Humana has established relationships with Head Start providers throughout the Commonwealth. In the past, we have conducted small sponsorships, and our Kentucky Medicaid Community Engagement team regularly participates in events and onsite education opportunities. Between April 2018 and March 2019, our Community Engagement team engaged with Kentucky Head Start organizations in Paducah, Murray, Christian County, Calloway County, Danville, Jessamine County, and Mayfield.

First Steps

When a Humana associate identifies 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 Enrollees to ensure they have linked with the appropriate First Steps office. With permission of the Enrollee's representative, we 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.

School-Based Services

With permission from the Enrollee's legally authorized representative, Humana shares the Enrollee's care plan (if in place) with their current school to assist in the coordination of school-based services. If we are aware of an existing Enrollee IEP, Humana coordinates with the school, Enrollee, and their caregiver to avoid duplication of services and to ensure our Enrollees know how to continue accessing services (such as Covered Services) through Humana during school breaks, after-school hours, or during summer months. We will work with our Kentucky Medicaid network providers to explore opportunities to increase school-based health services in support of the Commonwealth's State Plan Amendment to expand Medicaid coverage within these facilities.

Department for Community Based Services (DCBS)

Today, we maintain strong relationships with DCBS leadership through monthly and quarterly meetings. We will work collaboratively with DCBS to provide services and programs to enhance the self-sufficiency of families, improve safety and permanency for children in the foster system, and engage families and community partners in a collaborative decision-making process by becoming a key partner. We ensure our Enrollees are aware of the services DCBS provides, including SNAP, benefind, and child/adult protective services. As a mandated reporter, we have established protocols to ensure direct communications with DCBS in the case of abuse, sexual assault, neglect, and all emergency situations.

Kentucky Transportation Cabinet, Office of Transportation Delivery

Humana provides educational materials regarding the availability of transportation services and refers Enrollees for NEMT accordingly. We stay in contact with the Office to ensure our eligible Enrollees receive safe and reliable transportation to Medicaid Covered Services. Our SDOH coordinators, CMs, CHWs, and MSRs are available to help our Enrollees learn how to submit a request for NEMT through the Office's procedures. Additionally, we direct Enrollees with transportation barriers to public transport provided by the Kentucky

Transportation Cabinet. This collaboration helps provide low-cost transportation services (based on county) to Medicaid Enrollees through the Cabinet's brokers.

ADDITIONAL SERVICE PROVIDERS

In addition to the organizations mentioned above, Humana has developed procedures to work with several other organizations that frequently serve our Enrollees.

KY-Moms MATR

Our CMs will work with KY-Moms MATR to facilitate a referral if an identified pregnant Enrollee is determined to be at-risk for using alcohol, tobacco, or other drugs (e.g., opioids). Our CMs will continue to be involved with the Enrollee even after referral, including sharing care plans (with Enrollee permission) and attending care team meetings. Through this collaboration with KY-Moms MATR, we will also work with health departments, prenatal clinics, and Community Mental Health Centers.

Department of Aging and Independent Living (DAIL)

Humana identifies Enrollees under the oversight of Adult Guardianship using the guardianship indicator in the 834 enrollment file. We make every attempt to obtain the service plan completed by DAIL. If a care management need is identified via the service plan, we collaborate with DAIL to determine the appropriate level of care management. We will comply with the requirement in Section 35.0 Enrollees with Special Health Care Needs of the Draft Medicaid Contract to send monthly reports of adult guardianship clients to DMS 30 days after the end of each month. **In 2018, Humana served 180 Enrollees under the oversight of Adult Guardianship.**

At a minimum, Humana meets with DAIL staff monthly to identify, discuss, and resolve any healthcare issues and needs of the Enrollee as identified in the service plan or discovered through claims review. Meeting attendees include Humana associates, administrative staff of DAIL, and DMS representatives. Ongoing calls with Regional DAIL supervisors also aid in the coordination and care of Enrollees. Humana maintains our responsibility for care coordination with DAIL regardless of the Enrollee's participation in care management in order to ensure access to needed social, community, medical, and BH services.

Kentucky Commission on the Deaf and Hard of Hearing

Our CMs and other Enrollee-facing associates ensure that our Enrollees who are deaf or hearing impaired are linked with services offered by the Kentucky Commission on the Deaf or Hard of Hearing, including telecommunications equipment.

Kentucky Children's Health Insurance Program (CHIP)

Our associates are prepared to help uninsured members of our Enrollees' households link with supplemental resources, including Kentucky CHIP. In addition, we may refer Enrollees who have become Medicaid ineligible to apply for CHIP.

Cabinet for Health and Family Services (CHFS) Ombudsman

The Ombudsman can serve as an advocate for our Enrollees, reviewing and working to resolve customer issues with programs operated through CHFS departments. We include information about how to contact the Ombudsman in our Enrollee Handbook, and our Enrollee Services associates, care managers, and other Enrollee-facing associates may refer Enrollees to the Ombudsman upon request.

Social Security Administration

Our CMs, SDOH coordinators, and other Enrollee-facing personnel may refer eligible Enrollees – as identified through our comprehensive Enrollee assessment or other interactions - to the Social Security Administration to apply for Title XVI benefits.

a.vi.

Describe the Contractor's approach to ongoing review of its PHM Program, including potential real-time measurement, and how the Contractor will use results to address identified issues.

ONGOING REVIEW OF HUMANA'S PHM PROGRAM

Humana's approach to the ongoing review of our Kentucky Medicaid PHM program aligns with NCQA PHM standards. We are currently an NCQA-Accredited Health Plan, and our PHM program model is designed to address individual health needs at all points along the care continuum.

To evaluate the impact of our PHM program, we measure, track, and continuously monitor quality, cost and utilization, and membership experience. We align these measures to match the overall goals of our program, which helps determine if our methodologies are meeting the needs of Enrollees and other key stakeholders. If our analysis finds that a certain approach is not creating a positive impact, we identify opportunities for improvement. Acting upon this information expeditiously enhances our PHM program's effectiveness and helps to achieve the Triple Aim – better health, better care, and better value.

Humana will pursue the **NCQA Distinction in Multicultural Health Care**, as standards align with our values and enterprise goals, reinforcing our core mission of equitable access to care and reducing health disparities for our Enrollees and the communities we serve.

Leadership and Framework

Our **Kentucky Medicaid PHM Director, Dr. Adrienne McFadden**, will oversee the design and implementation of our PHM Program to address key determinants of health outcomes. Dr. McFadden will be a voting member of our **QIC**, ensuring Humana addresses population health priorities within our quality initiatives and overall strategy. While our PHM Director drives strategy and market-wide efforts to address population health, our care management team leads on-the-ground efforts to address the needs of individual Enrollees to deliver person-centered interventions for those with chronic and complex conditions. Dr. McFadden will work with our **Kentucky Medicaid Medical Director, Dr. Lisa Galloway**, to ensure the highest degree of integration between Humana's clinical programs and plan-wide initiatives and partnerships.

Quality Improvement Program

Humana's Kentucky Medicaid QIC is dedicated to overseeing our entire quality program and ensures quality improvement activities take place throughout the organization. Co-chaired by Dr. Galloway and our **Kentucky Medicaid Quality Improvement Director, Audra Summers, RN**, our **Kentucky QIC meets monthly** and will direct and review all quality management/quality improvement (QM/QI) programs. With the support of the leaders and supporting staff identified below, Dr. Galloway and Ms. Summers facilitate the integration of quality and operational processes across physical health and BH services through this analysis and evaluation of our QM/QI activities.



- Humana's **Kentucky Medicaid PHM Director, Adrienne McFadden, MD, JD**
- Humana's **Kentucky Medicaid BH Director, Liz Stearman, CSW, MSSW**
- Humana's **Kentucky Medicaid QAPI Coordinator, Brenda Stamper, RN**
- Locally-based quality improvement associates
- Support from Humana's national quality program



ASSOCIATE SPOTLIGHT:
Audra Summers, RN, PMHNP

Audra is proud to be Humana's Kentucky Medicaid Quality Improvement Director. She has been a Registered Nurse (RN) for more than 25 years, earned a Masters in Nursing Science with a focus on adult psychiatry/mental health in 2005, and has been with Humana for more than 20 years. In her previous roles, Audra was a HEDIS Consultant and a Senior Quality Improvement Professional within Humana's corporate Quality Operations Compliance and Accreditation team. In her current role, Audra oversees the Kentucky Medicaid Quality Improvement team, is responsible for implementing our Kentucky Medicaid QAPI Program, and co-chairs the QIC. Audra believes, "Utilizing data with strong processes and creating unique interventions with community partners will improve quality of care and health outcomes".

The QIC offers a vehicle to provide bi-directional feedback between Humana's operational and quality leaders, with the ultimate goal of improving outcomes for our Enrollees. Because of the multidisciplinary nature of the Committee, operational leaders can receive feedback on quality program challenges and offer ideas to resolve these barriers that may not be possible without the Committee's support.

MEASUREMENT

The most effective way for a health plan to evaluate the impact of its PHM strategy is to measure quality, cost and utilization, and membership experience. We assess our Enrollees to identify needs, employ strategies to improve the health and well-being of our Enrollee population, develop and implement interventions for key sub-populations, and continuously measure and monitor outcomes to adjust our approach. Humana will monitor and analyze the following types of metrics in our Kentucky Medicaid PHM program:

Clinical Metrics

- Performance Measures including HEDIS, AHRQ, State-defined
- Performance Improvement Projects
- Provider Outcome Data
- Clinical Program Outcomes
- Performance Assessment Report
- Practice Guidelines Monitoring
- AHRQ Patient Safety Indicators

Cost/Utilization Metrics

- Overutilization and inappropriate utilization
- Acute admits per 1,000 Enrollees
- Inpatient days per 1,000 Enrollees
- BH inpatient admissions per 1,000 Enrollees
- Rehabilitation admits per 1,000 Enrollees
- SNF average length of stay
- Readmission rates within 7, 14, and 30 days
- ED visits per 1,000 Enrollees
- Observation rate
- Post-discharge care coordination referral calls
- 3M PPEs metrics
- Use of opioids at high dosage
- Use of opioids from multiple providers

Membership Experience Metrics

- CAHPS surveys
- Potential quality of care issues
- Trend of services not meeting nationally-recognized criteria for medical necessity
- Current claims volume for the service
- Projected Enrollee impact

EVALUATION

Analytics and Reporting: Our **HEDIS dashboard** serves as our internal Medicaid HEDIS reporting tool. **Updated monthly**, it aggregates Medicaid Enrollee data, provides data with Enrollee-level detail, and helps define populations for pilot campaigns. This dashboard includes all HEDIS measures and sub-measures on which we report and trend performance, including a prior three-month trend and our performance relative to the 50th and 75th percentile bands, to monitor and assess progress on any measure. The dashboard can be filtered by market, region, and demographics to identify specific performance disparities.

Anvita is Humana’s internally managed HEDIS rules engine that allows us to **generate care gap reporting on a daily basis** in order to generate Enrollee alerts, inform predictive models, and produce provider reporting on open care gaps and needed preventive services. In addition, Anvita supports our rapid-cycle quality improvement activities. We also draw from a comprehensive set of data sources to inform any opportunities for improvement and associated initiatives. **Table I.C.24-14** below contains the quality data sources we use to inform and prioritize initiatives.

Table I.C.24-14: Quality Data Sources Used to Inform and Prioritize Initiatives

Report	Description
Inpatient Census Report	Daily detailed account of acute and sub-acute inpatient facility admission cases
3M PPEs Report	Identifies admissions, readmissions, facility-based complications, ED visits, and ancillary services that likely could have been prevented
Inpatient Clinical Dashboard	Weekly reporting of key operational metrics, such as time from receipt of authorization to nurse receipt, time for clinical decisions, discharge plan documentation, Enrollees contacted for post-discharge follow up, clinical program reach and engagement rate
Early Indicators Report	<p>Monthly reporting of key utilization metrics such as:</p> <ul style="list-style-type: none"> • Admits per 1,000 by utilization type (Acute, SNF, Rehab, LTACH) • Inpatient days per 1,000 • Length of service by type • ED visits per 1,000 <p>Dashboard format allows user drilldown for analysis by demographics, such as geographic region, plan type, and age of user</p>
High Utilizer Report	Monthly report allowing us to drill down into individual Enrollees with high utilization by service type (e.g., ED, inpatient care)
Provider Utilization Profiling	Quarterly provider-level report of claims and encounter data to analyze under and overutilization and to provide peer-to-peer analysis
Predictive Model Reporting	<ul style="list-style-type: none"> • Medicaid Severity Score Predictive Model, updated monthly • Readmission Predictive Model, updated daily from admission to discharge and integrated into our clinical platform, CGX, to trigger referrals for clinical programs • ED Predictive Model scores available by report each month, integrated into CGX • Opioid Predictive Model to enhance efforts to identify Enrollees at risk of opioid use disorder
Readmissions by Provider	Monthly tracking of 14- and 30-day readmission rates for acute admissions and provider visit within 14 days of discharge date

Table I.C.24-14: Quality Data Sources Used to Inform and Prioritize Initiatives

Report	Description
High-cost Prescription Report	Report identifies Enrollees who have 10 or more unique drugs that average more than \$250 per prescription

Our data analytics and reporting capabilities allow for near **real-time measurement**, enabling us to monitor, identify, strategize, and implement PHM strategies aimed at improving the health and well-being of our Enrollees. Additionally, our partnership with Epic will allow us to capture and monitor real-time data via EHRs.



Advancing Interoperability to Promote Real-Time Access to Health Information

Humana is the **first national healthcare insurer to collaborate with Epic** to bring together patients, providers, and payers to power value-based care. Humana and Epic are advancing interoperability to promote open communication and information transparency that will give patients and their providers integrated and real-time access to patients' medical history, health insights, and treatment options. This partnership will:

- Increase the breadth, quality, and timeliness of data exchange to better track quality measures and improve the breadth of Enrollee insights
- Reduce cost and improve the extent of specialty care by surfacing quality and cost information to providers as they make referral decisions at the point-of-care
- Improve medication adherence by presenting medication alternatives with cost information to providers while they prescribe
- Improve provider access to claims to support monitoring of value-based arrangement performance
- Reduce burden on providers and improve timeliness for PA decisions

Goal Setting: Following data analysis, we turn to setting measurable and reasonable goals for improvement. Our QIC uses the **SMART Goals methodology** to develop priorities within our PHM strategy. This methodology establishes the following guidelines for goal development:

- **Specific:** A clear and specific goal motivates and focuses efforts appropriately
- **Measurable:** A measurable goal can be used to track progress and motivate
- **Achievable:** Creating a realistic and achievable goal is important for a balance between maintaining motivation and stretching capabilities to achieve the goal
- **Relevant:** A relevant goal is important to the health plan and aligns with other goals
- **Time-bound:** A goal with a target date enforces the deadline for reaching a goal

IMPACT ANALYSIS

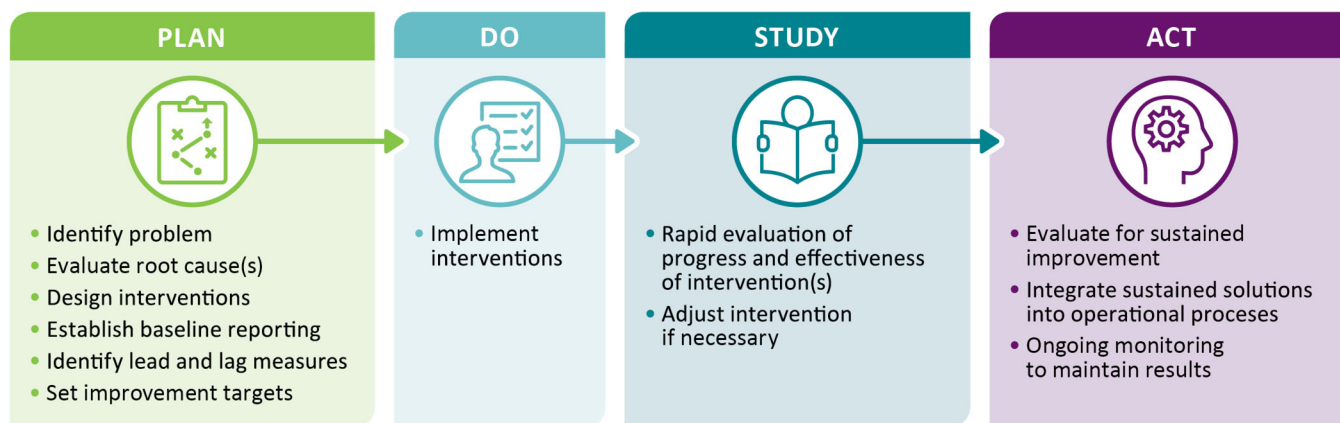
Root Cause Analysis: Humana deploys a rapid-cycle improvement process to quickly identify opportunities for quality improvement by analyzing adverse events and experiences. Once we identify gaps in care delivery, quality of care issues and/or disparities in health outcomes, we deploy **root cause analyses** to identify what happened, why the issue occurred, and establish preventive measures to decrease the likelihood of it happening again. This information helps us develop comprehensive and effective action plans that consider various causes of adverse events and experiences.

As a part of our root cause analysis process, we analyze trends and data based on geographic and demographic data, stratifying outcomes by race, ethnicity, language spoken, gender, and zip code. We use tools such as our **Community Health Dashboard** (for more details, please see our response to sub-question I.C.24.a.i) to map care needs and related indicators among the populations we serve. The application provides a better understanding

of the communities Humana’s serves and their comorbidities, utilization metrics, and socioeconomic environments in a visually rich and interactive web-based platform.

Test/Learn/Scale: Our approach in developing, maintaining, monitoring, and adjusting clinical and non-clinical initiatives stems from the **Plan-Do-Study-Act (PDSA)** data-driven improvement cycle (shown in **Figure I.C.24-19** below) that includes **rapid-cycle improvement methods** and **use of lead and lag measures**. This approach, paired with our monthly quality analytics reporting and evaluation, maximizes the PDSA cycle and drives material improvement as we determine if our interventions are producing the desired results. In cases where interventions are not producing desired outcomes, we are able to conduct a rapid-cycle root cause analysis and adjust our interventions accordingly.

Figure I.C.24-19 Plan-Do-Study-Act (PDSA) Process



Our quality improvement process identifies interventions that produce long-term and sustained results. We incorporate interventions that demonstrate both improved outcomes and sustainability into our operations, updating policies and procedures while continuing to monitor for sustainability of the improvement.

Humana’s PHM Program Evaluation Methodology in Action: Decreasing Non-Birth Maternity Admissions

From 2017 to 2018, we observed an increase in the percentage of non-birth maternity admissions in Humana’s Kentucky Medicaid program for Regions 2 and 4. We developed an initiative to identify pregnant Enrollees as early as possible and created an associated rewards program. Through claims, pharmacy, and encounter data, we were able to identify pregnancy terms, and CMs targeted those Enrollees with outreach calls and information on Humana’s maternity care management program, **MomsFirst**. We also utilized our **Kentucky Medicaid wellness and rewards program** to encourage expectant mothers to complete healthy activities and receive timely prenatal care, including routine doctor visits while they are pregnant and after their baby is born.

As a result, from 2018 to September 2019, **maternity admissions that were non-birth related decreased from 31% to 21% statewide**. From the third quarter of 2018 to the third quarter of 2019, non-birth maternity admissions per thousand **decreased 20% statewide (15.1 to 12.1)**. During this time period, **the rate of non-birth-related maternity admissions decreased by 56% in Region 2 and by 50% in Regions 7 and 8**.