

C. Technical Approach

25. Enrollees with Special Health Care Needs (Section 35.0 Enrollees with Special Health Care Needs)

a.

Describe innovative approaches and evidence-based practices the Contractor proposes to use in providing services to Enrollees defined in Section 35.0 “Enrollees with Special Health Care Needs” including. Include a summary of how the Contractor’s experience in providing services to these populations has informed the approaches.

Humana has more than 30 years of experience serving Enrollees with Special Health Care Needs (ESHCN). We bring best practices, lessons learned, and innovative models that have been developed and piloted across the country to ensure the best possible care for our Kentucky Medicaid Enrollees. We will adhere to requirements outlined in Section 35 ESHCN of the Draft Medicaid Contract and have policies, procedures, operational processes, and a robust support network in place to serve the following Enrollees:

- Children in/or receiving foster care or adoption assistance, if applicable
- Blind/Disabled Children under the age of 19 and related populations eligible for Supplemental Security Income (SSI)
- Adults over the age of 65
- Individuals experiencing homelessness (upon identification)
- Individuals with chronic physical health illnesses
- Individuals with chronic behavioral health (BH) illnesses
- Children receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Special Services
- Children receiving services in a Prescribed Pediatric Extended Care (PPEC) facility or unit
- Adult guardianship clients
- Enrollees with chronic BH illnesses, including Enrollees with serious mental illness (SMI) residing in institutions or at risk of institutionalization

In addition to the ESHCNs identified by the Commonwealth, we will also consider the following Enrollees as priority populations for our Kentucky Medicaid Managed Care (MMC) program.

- All pregnant women: Knowing the importance of early and ongoing care within the prenatal period, we make every effort to identify pregnant Enrollees as early as possible to address challenges they may face in obtaining adequate prenatal and postpartum care. All pregnant Enrollees are eligible to participate **in our maternity care management program, MomsFirst**. MomsFirst provides regular contact during the Enrollee’s pregnancy as well as follow-up contact during the six-week postpartum period. We tailor services and contact to the Enrollee’s acuity level as well as their contact preferences. **Of the pregnant Enrollees Humana served through our Kentucky Medicaid plan in 2018, we identified 12% as having substance use disorder (SUD) and 14% as having SMI**. 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 and in Kentucky, Kentucky’s placement rates have far outpaced the national average. **Between 2011 and 2018, Kentucky experienced a 34.6% increase in out-of-home placements**. To more fully engage with this crisis in the Commonwealth, 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 diagnoses of serious emotional disturbance (SED), as they are likely to be at a higher risk for out-of-home placement. Our goal is

that by identifying at-risk children earlier, Humana can leverage our integrated care management processes to support the Commonwealth's implementation of the **Family First Prevention Services Act** and coordinate with providers of family reunification services (i.e., Centerstone, KVC Kentucky) to assist in reducing the number of children entering foster care.

- **Persons who inject drugs:** Our Enrollee Needs Assessment includes questions regarding drug use including identifying injection drug use so that we may identify and assist Enrollees who screen positive. Humana recognizes the opportunity to improve health outcomes for these individuals by promoting trust and engagement with preventive healthcare providers and reducing judgment and burnout among providers of services to persons who inject drugs. **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. To support this population, we aim to:
 - Build partnerships with organizations serving this vulnerable population to encourage referrals of our Enrollees for Humana care management
 - Identify Enrollees who inject drugs with co-morbid physical health diagnoses (e.g., endocarditis and hepatitis C) for a high level of outreach and education concerning harm reduction techniques
 - Install processes to facilitate transitions for Enrollees who are receiving intravenous (IV) antibiotics for an infection associated with injection drug use from acute care settings to SUD residential settings (accompanied by home health care)
- **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 subsection I.C.25.b.i 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 a Kentucky Medicaid 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.

INNOVATIVE MODELS

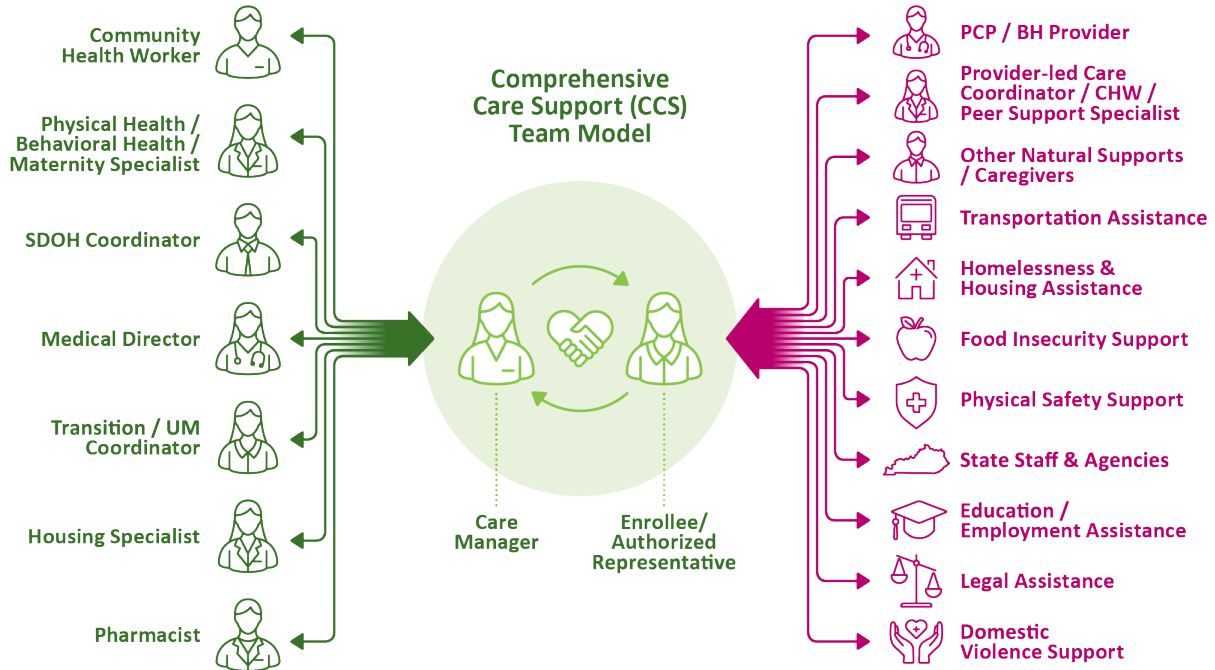
Kentucky Medicaid Comprehensive Care Support (CCS) Team

The CCS team is the anchor of Humana's Population Health Management (PHM) program. It is an integrated and collaborative team that includes physical health and BH clinicians, and other internal resources, who support Enrollees using a holistic and individualized care approach. Our integrated Care Manager (CM) supports the Enrollee to address barriers to achieving the highest possible level of wellness and reaching the highest level of functioning while managing both medical and BH needs. With the support and oversight of our Kentucky Medicaid Medical Director, Lisa Galloway, MD, the CCS team serves as a forum for dialogue and collaboration between Humana associates that encompasses all of the Enrollees' medical, BH, and social needs, including covered, carved-out, and non-covered services, and services delivered through third-party resources. Through collaboration within the CCS team and



among our associates, Enrollees, and providers, we advocate for the delivery of high quality, timely care that helps our Enrollees achieve their goals and remain in their preferred care settings. Please refer to **Figure I.C.25-1** for a complete view of our Kentucky Medicaid CCS Team Model.

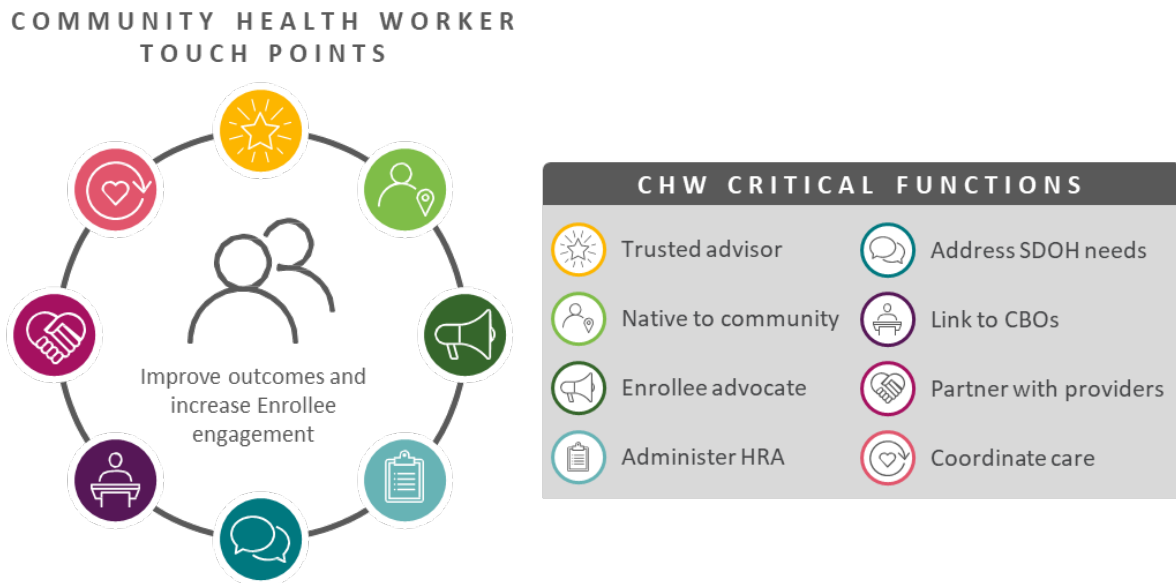
Figure I.C.25-1 Kentucky Medicaid CCS Team Model



CCS team associates include:

1. Care Managers (CM) (including physical health, BH, and maternity specialists) serve as our Enrollees’ single point of contact for care management activities and support. Our CMs oversee assessment, care planning, care coordination, and collaboration with the individual Enrollee’s multidisciplinary team (MDT). They are also responsible for maintaining regular contact with the Enrollee that meets or exceeds our minimum contact requirements.
2. Community Health Workers (CHW) are assigned to certain at-risk and high-risk Enrollees, at the CM’s direction, to provide a range of supporting functions, such as setting and/or going to appointments, accompanying Enrollees to access community resources, and providing education. CHWs support CMs, playing an important role in improving health outcomes and increasing Enrollee engagement. **Figure I.C.25-2** illustrates the multiple touchpoints of our CHWs.

Figure I.C.25-2 CHW Touchpoints



3. Social Determinants of Health (SDOH) coordinators are regionally based experts in community resources for SDOH. They manage a queue of Enrollees not in care management who need support accessing SDOH-related services. The SDOH coordinators also provide support and advice to CMs and CHWs to address SDOH-related needs for Enrollees in care management.
4. Our Kentucky Medicaid Medical Director, Dr. Lisa Galloway, oversees and provides support to CMs in fulfilling their responsibilities.
5. Transition/UM Coordinators work alongside our CMs and CHWs to ensure a seamless transition for Enrollees moving from one level of care to another, including supporting discharge planning.
6. Housing specialist(s) will be regionally based and report to our **Kentucky Medicaid Culture & Community Engagement Director, Bryan Kennedy**. These specialists serve as associate experts on resources available to address issues of housing and homelessness. These individuals will identify available resources to address individual Enrollee needs, build relationships with related support systems, oversee our **Kentucky Homelessness Outreach Strategy**, and play an important leadership role in the Homeless Respite model. Recognizing that there is a large population of veterans experiencing homelessness in Kentucky, these associates will also assist in connecting these Enrollees with related services provided by the Department of Veterans Affairs.
7. Our Kentucky Medicaid Pharmacy Director, **Joseph Vennari, PharmD**, will advise our CMs on medication use, including assisting with post-discharge medication reconciliation when needed.

Humana’s CCS team is an integral component of our program to support ESHCN. The team connects ESHCN with community resources (to include SDOH supports) and professional and long-term treatment for all identified Enrollee needs. The team partners with Enrollees to:

- Further holistic care, assessing the interaction of physical health, BH, and social needs
- Collaborate with the Enrollee’s providers and support network
- Address gaps in care to improve health outcomes
- Find resources and providers for all of the Enrollee’s health needs
- Assist in transition planning from different levels of care
- Educate the Enrollee and caregivers on symptoms and coping skills

Innovative Initiatives

Humana strives to identify and respond to needs at a community level. Driven by our data collection and analysis, Humana develops models to address community-specific issues. Examples of initiatives we have instituted in our Medicaid plans to date include:

- **Sickle cell disease (SCD):** During an analysis of claims data to assess drivers of inpatient readmissions, we found that SCD accounted for 15% of total readmissions among our Florida Medicaid Enrollees. In response to this trend, we partnered with specialists at Johns Hopkins University to create an SCD management program and an SCD Center of Excellence. The goal of this initiative is to identify and implement clinical best practices in managing SCD. Between January 2018 and January 2019, admissions per 1,000 decreased by 31% among adult Enrollees and 50% among adolescent Enrollees engaged in our Florida Medicaid SCD Management of Chronic Conditions program.
- **Field CMs and Social Workers:** Recognizing the need to engage more high-risk Enrollees in care management, we implemented a series of pilots in Florida that assign field CMs and field Social Workers to conduct visits at providers' offices. We paired this pilot with our Management of Chronic Conditions interventions to increase participation among Enrollees living with HIV/AIDS. We employed field CMs who are responsible for finding Enrollees living with HIV/AIDS in the community and making in-person contact to educate the Enrollee about our Management of Chronic Conditions program and benefits, with additional assessments and follow up if the Enrollee permits. As a result of this initiative, 61% of the eligible Enrollees identified during this pilot are now participating in the HIV/AIDS Management of Chronic Conditions program. Our Enrollees have experienced better condition management and improved outcomes, resulting in an average cost reduction of 48%.

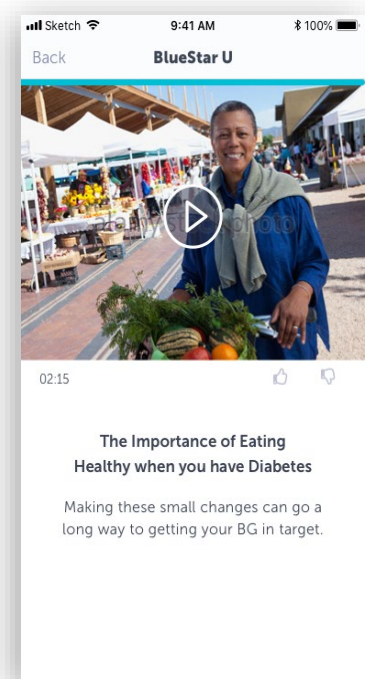
Enrollee Engagement Strategies

Humana is committed to improving outcomes for a variety of conditions, empowering our Enrollees with engagement tools, resources, and innovations that promote healthy behaviors and self-management. We will offer the following solutions (as appropriate) to individuals identified as ESHCN.

Remote monitoring: Humana has teamed with **WellDoc®** to provide Enrollees with a digital therapeutic application, BlueStar. BlueStar supports blood sugar control for persons with diabetes by providing real-time feedback on critical behaviors such as diet and exercise and by communicating lab results to the Enrollee and their clinical team. Humana's care management team will connect directly with Enrollees through a two-way chat functionality. In a six-month trial with Medicaid Enrollees, BlueStar resulted in a 55% reduction in hospital admissions and a 16% drop in emergency department (ED) visits. Please refer to **Figure I.C.25-3** for a snapshot of the BlueStar application.

Self-management tool: We will provide access to **myStrength**, a digital solution designed to improve self-management of BH and physical health conditions, including depression, anxiety, insomnia, chronic pain, and postpartum depression. myStrength offers online learning, self-help tools, wellness resources, and text-based, one-on-one coaching. These functions use evidence-based approaches, including cognitive behavioral therapy. Please refer to **Figure I.C.25-4** for a snapshot of the myStrength application.

Figure I.C.25-3 WellDoc BlueStar Mobile App



Maternity Care: To support our pregnant and postpartum Enrollees, we offer home health care, an innovative smartphone application, doula services, and postpartum outreach.

Home Health Care

Humana provides home support for our pregnant Enrollees. Through our vendor, **Optum®**, pregnant Enrollees at risk of pre-term birth can receive injections of 17 alpha-hydroxyprogesterone caproate (17P) at home. This medication is recommended by the American College of Obstetricians and Gynecologists for the prevention of preterm birth. By providing in-home care, we increase access to a crucial service that would otherwise require weekly trips to a provider’s office, potentially causing disruptions to the Enrollee’s work or child care schedule. Additionally, **Humana offers unlimited home maternity visits for high-risk pregnant Enrollees.**

Prenatal and Postpartum Care Smartphone Application

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.25-5 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.25-4
myStrength Mobile App

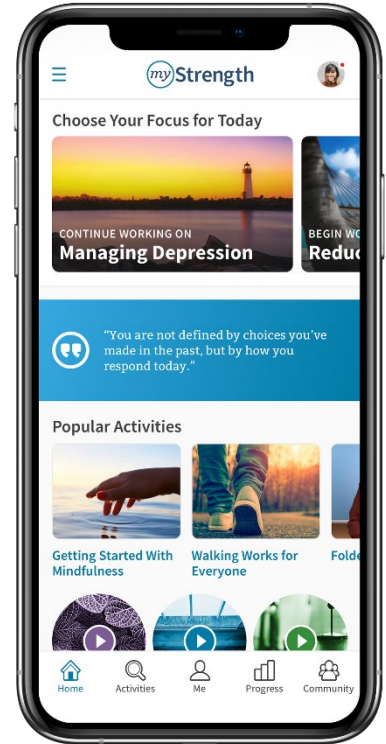


Figure I.C.25-5 Pacify Smartphone Application



Doula Services

As a base benefit, Humana covers doula services for pre and postnatal visits for requesting Enrollees. **As a value-added service, Humana will also cover doula delivery assistance services** for our Kentucky Medicaid pregnant Enrollees. The provision of doula services during delivery provides additional emotional and physical support to the woman while she is labor. In addition, it has been demonstrated to reduce birth complications and the incidence of Caesarean sections.

Postpartum Care Outreach

Our CMs make **postpartum outreach calls** to Enrollees engaged in MomsFirst who have delivered in the six-week postpartum period to ensure they complete a postpartum visit within 21 to 56 days. During this call, our CMs identify and address any barriers Enrollees identify regarding lack of transportation, child care needs, and other issues that might prevent them from attending their postpartum appointment as scheduled.

We also place a strong emphasis on recognizing and addressing postpartum depression and related conditions that may interfere with attaining the best possible health outcomes for mother and baby. During their postpartum follow-up calls, our MomsFirst CMs administer the Edinburgh Postnatal Depression Scale to assess the Enrollee for postpartum depression and link the Enrollee with appropriate services.

Face-to-face assistance: As noted above, Humana's Kentucky Medicaid CCS team model includes a CM and CHW working in tandem to ensure we are responsive to the needs of ESHCN. This model also allows the flexibility to provide **face-to-face assistance** to Enrollees as needed.

In-home urgent care: We will partner with home health providers in Kentucky to provide **mobile integrated health units** in an effort to prevent avoidable ED utilization. We will educate frequent ED utilizers and identified Enrollees with high-need, high-cost conditions on how to contact our Medical advice line for non-life-threatening situations and the BH Crisis Line as a resource in emergency situations. The Medical advice line associate will then assess the Enrollee and contact one of our contracted home health providers if in-home urgent care services can be provided in lieu of an ED visit.

Kentucky Homelessness Outreach Strategy

Humana has developed a comprehensive strategy to support the health of all Enrollees. We recognize individuals experiencing homelessness and those who are at risk of homelessness face increased health and financial risks. Humana's approach to combating homelessness emphasizes implementation of evidence-based interventions and partnerships with Community-Based Organizations (CBO) to sustain the work that is already being done. Our approach not only seeks to provide the critical services needed to assist individuals experiencing or at risk of 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.



Community-Based Partnerships

We understand some Enrollees may be hesitant to identify as homeless and seek help or may not know how or where to seek help. Humana will therefore leverage the referrals and relationships in place with **Housing and Urban Development Continuum of Care organizations** to provide housing options statewide to our Enrollees. We have established partnerships with organizations including **Volunteers of America Mid-States (VOA), Coalition for the Homeless in Louisville, Legal Aid Society, and domestic violence shelters** across the Commonwealth. Our partnerships with VOA and the Legal Aid Society will bring targeted supports to help at-risk Enrollees avoid eviction, offering services to help prevent eviction in the first place. We intend to deepen these partnerships through a mutual commitment of delivering impactful services to our Kentucky Medicaid Enrollees and look to support capacity-building efforts through a mix of capital investment and appropriate reimbursement in return for quality and community impact.

WellSpring Partnership

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, work to prevent homelessness, unnecessary hospitalizations, and other adverse outcomes. A key goal of the program will be avoiding chronic homelessness and preventing our Enrollee from returning to a shelter by stabilizing the individual in a setting that is most appropriate for their medical and behavioral needs.

WellSpring will collaborate with our Kentucky Medicaid care management team to provide the following services and supports to these identified Enrollees:

- WellSpring's care team includes a psychiatrist, nurse, clinical social worker, peer support specialists, CM who specializes in services to the SMI population and brokering housing support, and an employment specialist
- Available 24 hours a day, 7 days a week, WellSpring will provide real-time support in a crisis situation to include a multidisciplinary team for discharge planning support from the ED
- Wraparound services from WellSpring include supportive housing, therapy services, transportation, medication management, group sessions, and crisis assistance

Innovative Solutions

Humana is committed to making investments in solutions that tackle housing insecurity and other underlying challenges that lead to homelessness. Drawing upon our experience 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 for 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 to provide education and an avenue for early identification of at-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 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 our Enrollee
- Negotiate with the housing authority and/or landlord on behalf of our Enrollee
- Provide legal aid and support to individuals in need

Upon identification of housing insecurity risks, referrals will be made to VOA case managers. 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 medical needs that may be related to housing insecurity and ensure appropriate referral to, and coordination with, our care management team.

Medical Respite Care: Our **medical respite** solution 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 reducing hospitals' costs. Humana's medical respite program will therefore help to reduce the chance of readmission and additional health complications for individuals experiencing homelessness. Our medical respite pilot program (a partnership with VOA) will provide the time necessary to help the individual secure stable housing and get critical supports to improve their housing security and thus their overall health.

VOA, which has extensive experience with respite care in recent years, is currently operating a similar effort in partnership with an infectious disease specialty practice in Kentucky. This program provides transitional care and support for individuals diagnosed with infectious diseases related to intravenous drug use who must continue infusion therapy for 40 days following discharge from inpatient admissions but, due to risks associated with addiction and housing insecurity, cannot do so safely or reliably on their own. VOA provides housing, counseling, and support for these individuals, as well as medical assistance to ensure successful completion of infusion

therapy. Humana plans to support the continued expansion of this focused respite approach for our Kentucky Medicaid Enrollees.

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.

The pilot program’s impact will be rigorously measured with focus on the following outcomes:

- Reduced readmissions and utilization of the ED
- Connection with a Primary Care Provider (PCP), psychiatrist, and SUD counselor
- Reduced inpatient length of stay
- Improvement in health status and quality of life

BH Provider Partnerships

We know that BH is as essential to the well-being of our Enrollee population as physical health. More than one-quarter of our Kentucky Medicaid Enrollees have a BH condition, including 10% with an SMI diagnosis and 13% with an SUD diagnosis. Humana is committed to addressing the BH needs of our Enrollee population through a fully integrated, internally built BH model of care, as well as innovative provider partnerships that leverage the expertise of Kentucky’s BH system to ensure our Enrollees receive evidence-based, high quality services, whatever their diagnoses and circumstances.



Centerstone: As a leading provider of BH services in the Kentucky region, with 26 locations in the greater Louisville area, Centerstone serves more than 34,000 Kentuckians through addiction recovery, mental health, and counseling services, among other offerings. Humana and Centerstone will work together to share information on available residential beds and crisis supports in Centerstone facilities, contributing to Humana’s design of an active crisis bed registry in the Commonwealth. Humana and Centerstone will also identify and serve our pediatric Enrollees who are at-risk for foster care placement, providing services and interventions to remain in the home and therefore, strengthen and preserve their family unit.

KARP: We are in active discussions with KARP, Inc. regarding a proposal to **pay a care coordination Per Member Per Month (PMPM) fee to its member Community Mental Health Centers (CMHC)**. 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 to pay care coordination fees to member Federally Qualified Health Centers, will give our BH providers the additional resources needed to support administration and care coordination tasks, including discharge planning for Enrollees with 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 for this bundled payment to lessen this burden and promote delivery of High Fidelity Wraparound supports to our child and adolescent Enrollees with BH needs.

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We are looking forward to working with Humana to implement a value-based program that incentivizes all parties, across the spectrum of providers offering preventive services, evidenced-based therapeutic interventions, intensive outpatient, inpatient residential, inpatient hospitalization, and emergency department services to work together across the continuum of care.
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– Abbreial Drane,
President & Chief Executive Officer, Centerstone

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. Ahead of the Commonwealth's adoption and implementation of the Family First Prevention Services Act, providers like KVC Kentucky will be essential to providing high quality prevention services that reduce the number of children entering the foster care system in Kentucky. With a commitment 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, work to complete appropriate assessments, and arrange appropriate services and interventions to keep the child in their home, including offering parenting classes and other 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.

Springstone: To preserve a continuum of care for our Enrollees with BH needs, Humana is partnering with **Springstone** to expand access to intensive outpatient and partial hospitalization programs in Kentucky. Springstone is a national provider of high quality BH solutions with a reputation for bringing new services to populations in need of mental health and SUD support. Under this arrangement, Springstone will establish new locations in Kentucky, expanding access for Medicaid Enrollees and the Commonwealth as a whole.

SUN Behavioral Health: 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 rates.

In-network psychiatric hospitals: Humana has contracts in place with all psychiatric hospitals and distinct part units in the Commonwealth, including Appalachian Regional Healthcare, Eastern State Hospital, Central State Hospital, Western State Hospital, Baptist Health, and Universal Health Services facilities. Our agreements with these Kentucky-based facilities include a description of the responsibilities of the BH service provider to ensure continuity of care for a successful transition back into community-based supports. We will continue to ensure our Kentucky Medicaid BH providers participate in quarterly continuity of care meetings hosted by State-operated or State-contracted psychiatric hospitals.

Humana will also work with State-operated and State-contracted psychiatric hospitals to allow our CMs to provide face-to-face discharge planning support with the Enrollee's permission. The onsite presence of the CM will support the remote work of our UM Coordinator and ensure we possess a full understanding of the Enrollee's needs prior to discharge. This is similar to our plan to place onsite Nurse Liaisons in high-volume medical-surgical facilities in Kentucky, as we have for our Medicare plan in Kentucky and our Medicaid plan in Florida.

Coordination for Children in/or receiving Foster Care or Adoption Assistance

Humana is already serving foster care children in Kentucky, with well-established lines of communication and relationships with the Department for Medicaid Services (DMS), Department for Community Based Services (DCBS), and Department of Juvenile Justice (DJJ). To facilitate enhanced coordination and integration for the Kentucky SKY program, Humana will partner with the Managed Care Organization (MCO) awarded the Contract to serve Enrollees in the foster care system. Our continuity of care process is designed to ensure a seamless experience for this population, with each step developed to meet Enrollees' needs and prevent any disruptions in their care that may have serious effects on their health and well-being. We will work with the MCO serving Kentucky SKY Enrollees to transmit all relevant

In 2019, Humana served 2,406 foster care Enrollees under our Kentucky Medicaid plan.

information (including health records, assessments, and care plans) for foster care Enrollees and will educate these Enrollees, their foster families, and our network providers on what to expect from the transition. We will employ a similar process for Adoption Assistance recipients who may be transitioning to their adoptive parents' health plan.

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 the Court Appointed Special Advocate (CASA) of the River Region. This grant will support CASA's Giving Children Childhoods project, focused on expanding BH and Adverse Childhood Experiences (ACE) screenings for engaged children; expanding access to an individualized, trauma-informed reading program; and establishing formal collaborations with addiction specialists to expand service delivery.

EVIDENCE-BASED PRACTICES

Our experience meeting the needs of ESHCNs by coordinating covered medical and BH care alongside additional non-Covered Services and third-party resources has given us tremendous perspective and expertise. We have continued to evolve our approach to ESHCNs in response to changing needs and continue to identify best practices to improve our programs and processes across the enterprise.

Humana's approach to care management for ESHCN is deeply rooted in the application of evidence-based practices. Key elements incorporated into our model include:

- **Coordination with providers:** Through our provider portal, **Availity**, providers serving our Enrollees, including primary care and BH providers, can access a summary of the Enrollee's medical history, results of assessments, and their comprehensive and integrated care plan. In addition, our **Population Insights Compass (Compass)** offers our providers expanded population health data to manage the health of their patients and better inform their outreach and care, including integration of physical health and BH services. Compass offers our providers quality reports identifying Healthcare Effectiveness Data and Information Set (HEDIS) gaps in care, an actionable list of Enrollees who are at-risk for non-compliance with medication adherence, and access to patient detail reports, which provide an in-depth look at each Enrollee on their patient panel including demographics, visit history, diagnoses, HEDIS gaps, authorizations, physician visits, and clinical program participation.
- **Fully integrated care management model:** In alignment with our PHM commitment to deliver approaches that meet the wide variety of needs of the individuals we serve, our integrated care management program (including our CCS team) serves the diverse and often complex physical health, BH, and SDOH needs of our highest-risk Medicaid Enrollees.
- **Integrated Care Plan:** Our care plan development process is person-centered and Enrollee-driven, with the support of the Enrollee's representative and other members of their chosen support system. Using the assessment 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 improved self-care. The care plan is designed to be comprehensive, including the Enrollee's physical health, BH, and social needs. Our CMs complete the care plan in real time, in conjunction with the Enrollee and their support system, using our integrated clinical platform, **Clinical Guidance eXchange (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. Annually, with an Enrollee change in condition or current level of care, or upon request, we will complete updates to the care plan based on Enrollee needs and ensure we communicate the care plan to the Enrollee and their PCP. During subsequent care management meetings, we will discuss the Enrollee's progress toward their goals and identify any needed services. We will update care plans in compliance with 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 of a member of the MDT.

- **Transitions of care:** For transitions between care settings, Humana adheres to the Dr. Eric Coleman Care Transitions Model, which is grounded in improving quality and safety during transitions and includes five pillars of transitions that emphasize coordination, medication management, establishment of a medical home, education for Enrollees and caregivers, and comprehensive staffing to support the transition. Our approach to implementing this model is further described in our response to subsection I.C.25.b.iv.
- **Focus on cultural competency:** Our **Kentucky Medicaid Culture & Community Engagement Director, Bryan Kennedy**, is responsible for the oversight of our cultural competency program, including adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. In addition, he oversees expansion of our cultural support for Enrollees beyond National CLAS Standards. We promote sensitivity to cultural diversity and educate our associates on the impacts culture has on how Enrollees engage with the healthcare system. We are committed to continuous development and training and to providing resources on culture and diversity for our associates and providers. We require our providers to participate in orientation, annual trainings, and education sessions. Cultural Competency training modules are also mandatory for all associates upon hire with refresher courses held annually and on a corrective action basis if we identify a deficiency. We also require specific training that includes content tailored to the Medicaid population. This includes topics such as Health Literacy and Numeracy, Cross-Cultural Negotiation, and Understanding Seniors and People with Disabilities. We further enhance our training for Enrollee-facing associates to meet the social, cultural, religious, and linguistic needs of all Medicaid Enrollees and subpopulations.
- **Direct access to home health without referrals/authorizations:** We provide Enrollees with the option to receive home health services with just an order from their PCP, eliminating the barrier of requiring a referral or authorization. This will improve access for Enrollees, like many of our ESHCNs, who cannot receive services in a traditional care setting or have trouble doing so.
- **Advanced care planning:** The CM will educate the Enrollee on the process for and importance of developing an advance care plan in the event that they are not able to make care decisions for themselves in the future. If the Enrollee is interested, our CM will help them complete the needed documents.
- **Integrated clinical platform:** Over the last several years, we have made significant investments in our integrated clinical platform, CGX, to support the efficient delivery and coordination of all Covered Services. **CGX's functionality enables the direct management of medical, BH, and SDOH services**, enhancing our ability to document gaps in care, automate care planning, monitor plan compliance, and proactively address co-occurring BH and medical needs and changes in condition.
- **Family-based care management:** We use a family-based care management approach, assigning a single CM to all Humana Enrollees receiving care management in a single household to ensure we fully address family needs, goals, and preferences. By ensuring the family has a single point of contact with Humana, we streamline the care management process for Enrollees.
- **Field care management:** Based on successful pilot initiatives testing the efficacy of field-based CMs and CHWs in our Florida Medicaid program, Humana will also offer field care management to our Kentucky Medicaid Enrollees when indicated.
- **Weekly clinical rounds:** We hold weekly clinical rounds to discuss complex cases and high utilizers that our CMs identify. These rounds bring together our interdisciplinary team including Medical Directors, Utilization Management (UM) associates, and CMs to supply expert guidance and support for meeting the needs of each Enrollee. We employ this integrated practice in other markets as well, which has fostered collaboration, relationship-building, and multidisciplinary clinical practice and learning.

In 2019, Humana was named to DiversityInc's list of the **Top 50 Companies for Diversity**, the most rigorous, data-driven analysis of diversity management practices in corporate America.

We monitor CM performance through our quality audit process to promote adherence to evidence-based practices. Once these associates communicate the audit results to our CM managers, and based upon individual results, the manager will address any identified gaps or concerns through refresher training on key concepts, or work with our Clinical Learning and Development (CLD) team to develop new training, if needed. For example, through our quality audit process, we identified that our CMs serving our Illinois Duals Demonstration Enrollees were having difficulty creating Specific, Measurable, Attainable, Relevant, and Timely (SMART) goals. In response, we launched extensive re-training on this key concept.

EXPERIENCE

Humana has served ESHCN nationwide for more than 30 years. Today, approximately 22%, or 32,000, of our Kentucky Medicaid Enrollees are stratified in risk tiers that qualify for one-on-one care management, in addition to the Enrollees who qualify for our **maternity care management program, MomsFirst**, which aims to engage pregnant Enrollees of all risk levels, providing services and supports tailored to meet individual needs and risk level. Humana currently services 2,596 Enrollees through our Dual Eligible Special Needs Plan (D-SNP) in Kentucky.

We engage more than **1,300** Enrollees in our Florida MomsFirst program each month. Between 2017 and 2018, this program contributed to a **10.3%** decrease in maternity-related readmissions.

We also have extensive experience serving more than 35,000 Enrollees with complex needs through our Managed Long Term Services and Supports (LTSS) and Centers for Medicare and Medicaid Services (CMS) Duals Demonstration plans in other states. Humana serves more than 280,000 Dual Eligible Enrollees through our D-SNPs in 24 states and Puerto Rico, including almost 8,000 Dual Eligible Enrollees through our Duals Demonstration plan in Illinois. We have experience identifying opportunities to effectively address Enrollee needs in these programs and creating targeted initiatives to produce measurable results. For example, in Illinois we introduced a Skilled Nursing Facility (SNF) program to address preventable hospital admissions and readmissions to nursing facilities. These efforts resulted in a decrease in readmission rates and hospitalizations per month. These Enrollees have many similar characteristics, needs, and acuity levels as ESHCN enrolled in the Kentucky MMC program.

Humana's care management program has been proven to improve care and health outcomes for our Enrollees. **In 2017, Enrollees in Kentucky engaged in our Complex Care Management program experienced a 17% decrease in ED utilization, a 40% decrease in inpatient admissions, and a 36% decrease in overall medical costs.**

b.

Describe the Contractor's approach to facilitate access to appropriate services for Individuals with Special Health Care Needs to include:

Our person-centered, holistic model of care guides our approach to promoting the health and wellness of ESHCN. As described below, we identify ESHCN upon enrollment and on an ongoing basis. For those ESHCN identified, we make a best effort to conduct the HRA within 30 days. Based on this assessment and the subsequent Enrollee Needs Assessment, Humana will determine if there is a need for care management outreach and monitoring. If so, we assign our Enrollee to a CM to begin the process of developing a care plan and course of treatment where indicated. In line with our commitment to empowering our Enrollees to make informed healthcare decisions, Humana has developed condition-specific information and materials that we provide to our ESHCN (and their support network).

Humana maintains a 360-degree view of our Enrollees to facilitate access to the full range of appropriate services for ESHCN. In addition to our physical health, BH, and maternity CMs, our CCS team includes associates dedicated to supporting and coordinating access to SDOH-related services. Our SDOH coordinator will provide

CMs and CHWs assistance in identifying and locating needed support services. The Housing specialist will assist in the process of navigating available resources and possible placement options.

Humana has also implemented processes to remove barriers to care, such as removing prior authorizations (PA) for the traditional outpatient BH services and eliminating PA for preferred Medication Assisted Treatment (MAT) products to help address opioid dependencies among our Kentucky Medicaid Enrollees.

Integration is also a critical element in our approach to effectively facilitate services. Our Enrollee care plan is comprehensive, encompassing the Enrollee's physical health, BH, and SDOH needs. This allows us to identify needs across the spectrum simultaneously, prioritize and address them appropriately, and avoid duplicative services. Additionally, to ensure our care management and UM processes are closely aligned, UM and CM associates meet in twice weekly rounds and maintain ongoing communication. UM reports are shared with the care management team and reviewed monthly to assess service access.

b.i. Approach to identifying Enrollees.

We identify ESHCN upon enrollment and on an ongoing basis using a variety of methods, including (but not limited to) the sources listed below. We maintain a list of screening triggers (such as utilization, inpatient, or SNF admissions; pregnancy, homelessness, or the victim of domestic violence identifications; or treatment for any condition we identify as a chronic condition) for our associates to use as a guide to further maximize timely and accurate identification of ESHCN.

We use the following sources to identify ESHCN upon initial enrollment in Humana:

- Enrollment data and supplemental files: We review enrollment and other supplemental files received from DMS to identify those Enrollees with the conditions or care needs corresponding to an ESHCN.
- HRA: We conduct an initial HRA for all new Enrollees, described below. Through this screening, we may identify Enrollees who will receive further assessment to determine if they meet the criteria listed in Section 35.0 ESHCN of the Draft Medicaid Contract.
- Historic claims: We review all historic claims data supplied by DMS, as well as historic information provided by the Enrollee's previous health plan (if any), to identify Enrollees who meet the criteria listed in Section 35.0 ESHCN of the Draft Medicaid Contract.

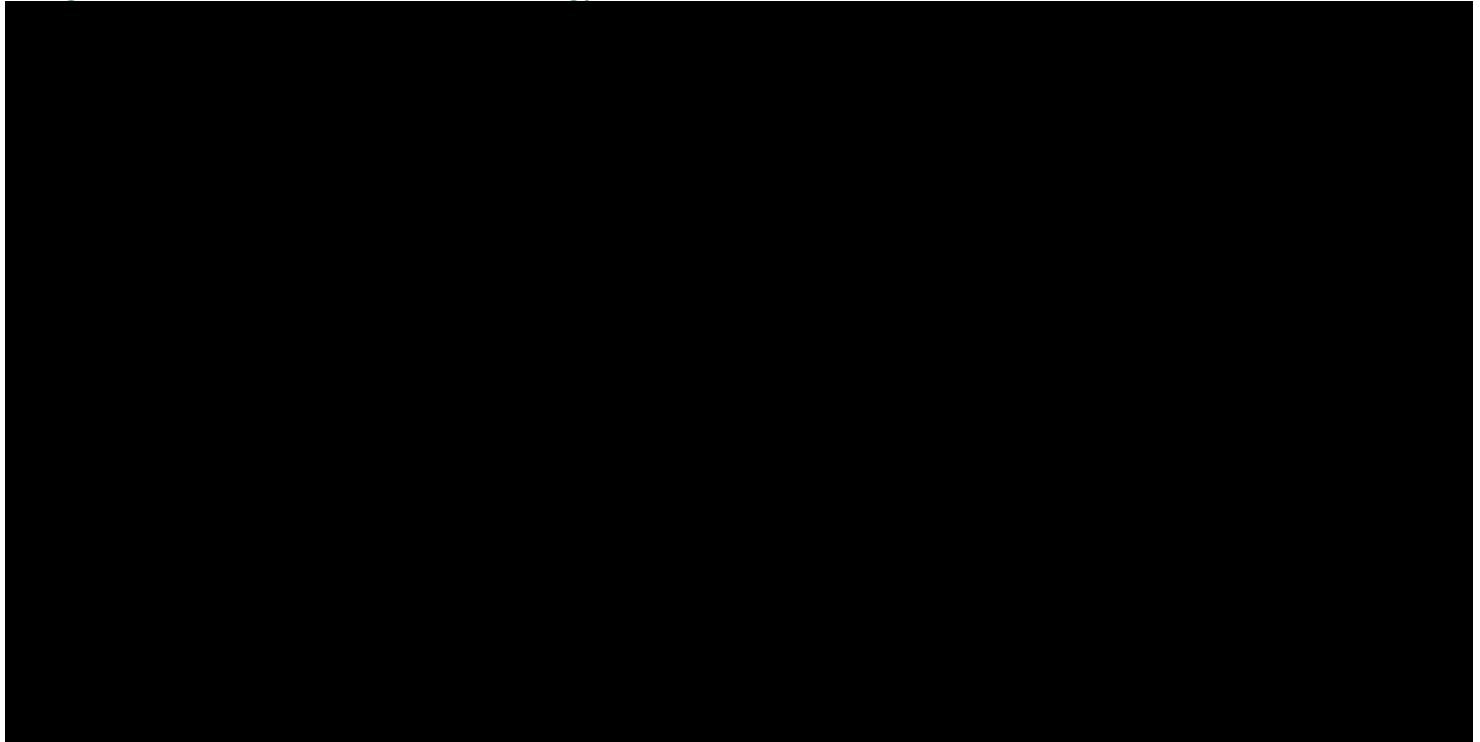
Ongoing identification methods include:

- Predictive Models: We use our proprietary Medicaid Severity Score Predictive Model, Readmission Predictive Model, and ED Predictive Model to identify Enrollees with high costs, clinically complex health conditions (including BH needs), and/or a high likelihood of readmission or ED utilization. By analyzing a broad array of data, we identify Enrollees with a change in condition who may benefit from care management.
- Post-Discharge Screening: Enrollees discharged home who are identified as high-risk or medium-risk by our Readmission Predictive Model (or were previously identified as ESHCN) receive a post-discharge screening. One of our associates administers this screening via telephone to identify gaps in care, document appropriate interventions, and detect Enrollees with complex needs, high-cost care, or other conditions who may benefit from our care management programs with a dedicated CM.
- Claims and Encounter Data: We review claims to identify Enrollees who are receiving services or who have the conditions listed in Section 35.0 ESHCN of the Draft Medicaid Contract. We also use claims data (including pharmacy data) to identify Enrollees who have high-cost catastrophic cases or high service utilization who may qualify as ESHCN.
- Provider or other agency referrals: Providers and other agencies can refer Enrollees for further assessment as ESHCN. Our PHM program description is featured on our website and in our Provider Manual, along with contact information and a referral form.

- Self-identification: Enrollees may request to be assessed by Humana to determine if they meet the criteria for ESHCN. We include descriptions of the PHM program for ESHCN in the Enrollee Handbook and other Enrollee information materials, including how the Enrollee can self-refer for care management.

Figure I.C.25-6 illustrates Humana’s clinical technology platform, which includes many of the sources and systems previously mentioned.

Figure I.C.25-6: Humana’s Clinical Technology Platform



SPECIALIZED IDENTIFICATION FOR ADULT GUARDIANSHIP CLIENTS

Humana identifies adult guardianship clients as ESHCN using the guardianship indicator in the 834 enrollment file. We make every attempt to obtain the service plan completed by the Department for Aging and Independent Living (DAIL). The service plan informs the need for care management, and if a need is identified, Humana collaborates with DAIL to determine the appropriate level of care management. We will comply with the requirement in Section 35.0 ESCHN of the Draft Medicaid Contract to send monthly reports to DMS 30 days after the end of each month.

SPECIALIZED IDENTIFICATION FOR ENROLLEES EXPERIENCING HOMELESSNESS

Humana recognizes that we need to take additional steps to identify Enrollees experiencing homelessness. We will develop a customized outreach plan for homeless individuals, including special considerations for those who are experiencing homelessness or are victims of domestic violence. In our Kentucky MMC program, Humana serves approximately 550 Enrollees experiencing homelessness.

Understanding the negative downstream impact of homelessness on health and quality of life, we have designed a multi-pronged approach to identify Enrollees currently experiencing homelessness and at risk for homelessness, in addition to those who would benefit from our medical respite program. This includes (but is not limited to) identifying 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 we identify Enrollees as experiencing homelessness, we (together with our partners) will communicate

available services and our value-added services offerings, such as medical respite. As noted above, Kentucky has a large population of veterans who are experiencing homelessness; we will coordinate with services offered by the Department of Veterans Affairs to fully engage these Enrollees.

We will identify eligible Enrollees during the discharge planning process at hospitals, as well as via referrals by a family member, PCP, or other CBOs. Our CHWs will assist Enrollees through the transition process, helping them complete forms and gather needed information, while providing face-to-face assistance and other supports to establish a new residence. Behind the scenes, our Housing specialist will help our CMs and CHWs identify available resources in the community where Enrollees reside and identify options for short- and long-term placements. Humana will educate our Kentucky Medicaid hospital network and our UM/Transition coordinators responsible for discharge planning on the availability of the program, the eligibility criteria, and the referral process. Our UM/Transition coordinators, in turn, will notify our CMs of the admission and referral for medical respite. If an Enrollee is not yet engaged in care management, we will invite them to participate as an ESHCN. Our integrated clinical platform, CGX, will notify the CM when an Enrollee known to be experiencing homelessness and engaged in care management is hospitalized. Humana CHWs play an important role in performing feet-on-the-street activities to engage our most difficult-to-reach Enrollees, including Enrollees who are experiencing homelessness. **In line with those responsibilities and demonstrating Humana's commitment to meeting our Enrollees where they are, we will engage with providers of homelessness services across the Commonwealth to explore the opportunity to place a Humana CHW onsite at their service sites to meet with Enrollees.**

b.ii. Process for screening and assessing individual Enrollee needs.

WELCOME CALL AND INITIAL HEALTH RISK ASSESSMENT (HRA)

Within 30 calendar days of enrollment, we make at least three attempts to complete the initial HRA with Enrollees identified as ESHCN on the enrollment file. To maximize completion of the HRA within the initial 30-day period, we will make a minimum of six HRA completion attempts for all Enrollees, exceeding state requirements. **To encourage all Enrollees to complete the HRA, we provide incentives for completion.** We re-administer HRAs at least annually for ESHCN. We will take the following sequential steps to reach our Kentucky Medicaid Enrollees:

Between January 1 and January 29, 2020, we completed 6,394 HRAs among 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. *HIPAA-compliant postcard:* We will mail one, HIPAA-compliant postcard asking the Enrollee to call our Member Services Call Center for assistance. This will be sent after the 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 telephonic 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 or ESHCN status on the HRA (or those who request contact from a Humana representative) are automatically referred to our care management team for further assessment and support.

Methods of Completion

In addition to the formal mail and telephonic attempts that occur within the first 30 days of enrollment, 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 Member Services Representatives (MSR) when an Enrollee with an uncompleted HRA contacts Humana's Member Services Call Center or visits a **Humana Neighborhood Location**. The MSR can then 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 this 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 partner counterparts 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.

Enrollee Incentives

Humana is committed to completing HRAs within the contractually required timelines for new Enrollees and annually thereafter. As such, all Enrollees are eligible to receive a reward incentive for annual HRA completions, redeemed through our Go365® Enrollee incentive platform.

UNABLE TO CONTACT (UTC) PROCESS

Our experience in serving Medicaid populations has underscored the challenges 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 UTC 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 will leverage data mining techniques and relationships with providers and community partners 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 manage our Medical advice line, BH Crisis Line, and dental and vision services
- Contacting assigned PCPs, pharmacies, and CBOs (such as homeless shelters) to determine if they have obtained updated or alternative contact information

Through our advanced data analytics systems and predictive models, we utilize the data that we do have available to us – including data from enrollment files and any received claims – to identify ESHCN. Our CHWs will perform additional outreach to our ESHCN, 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.

Commitment to continuous quality improvement in HRA completion

We regularly assess HRA completion rates among Enrollee cohorts, including ESHCN, and tailor our interventions to improve our performance and more effectively reach Enrollees. We will draw upon the success of our Florida Medicaid plan, where we effectively increased HRA completion rates for several key population groups, including Enrollees with SMI, asthma, diabetes, and Enrollees who are pregnant. Through the implementation of focused call campaigns, including authorization of additional associate work hours to complete calls in the evening and weekends, we exceeded State benchmarks for these key populations. We have summarized the results of our Florida HRA initiative in **Table I.C.25-1** below.

Table I.C.25-1: 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

Through the initial HRA process, we identify ESHCN for completion of the Enrollee Needs Assessment, which is a more comprehensive assessment than the HRA and is designed to identify the types of care management supports that would benefit the Enrollee. The Enrollee Needs Assessment is completed via telephone, in-person (as indicated), or by another method deemed appropriate. We make a reasonable effort to complete the Enrollee Needs Assessment within 30 days of identifying an Enrollee in potential need of care management services or within an earlier timeframe for Enrollees identified as having more immediate needs. Humana currently stratifies Enrollees into the four PHM tiers, as depicted in Table I.C.25-2 below. Depending on the Enrollee’s acuity level, the assessment may be completed by a Registered Nurse (RN), Nurse Practitioner (NP), Physician’s Assistant (PA), clinically licensed BH professional, master’s level BH professional with certification or licensure, Professional Counselor, Licensed Psychological Practitioner, Licensed Psychological Associate, or an associate with a graduate degree in social work or related field.

Our assessment focuses not only on identifying the Enrollee’s health needs but also potential barriers to care. These include (but are not limited to) an Enrollee’s knowledge of their disease state, 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 food security. Our Enrollee Needs Assessment addresses all

Table I.C.25-2: Humana Enrollee PHM Stratification, 2019

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

elements required by the Commonwealth and additional elements (**in bold type**) to ensure we fully understand the Enrollee’s background, needs, goals, and preferences. Elements of our Enrollee Needs Assessment include:

- Enrollee goals and preferences
- Review of SDOH needs, including housing, food insecurity, physical safety, transportation, education, and employment

- Assessment of psychosocial, functional, and cognitive needs
- Enrollee's 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), SUD, SED, and tobacco usage, among others
- Clinical history, including prescribed drugs and over-the-counter medications
- Current services, including 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**

For Enrollees under the oversight of Adult Guardianship, the service plan developed by DAIL determines the Enrollee's needs, including the need for care management services. 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. We may also meet with DAIL staff after an increase in acute service utilization. Meeting attendees include Humana associates, administrative staff of DAIL, and DMS representatives. Ongoing calls with the 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 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. In 2018, Humana served 180 adult guardianship clients; more than 80% had a BH need, 47% were Dual Eligible, and there was an average of 1.5 ED visits per Enrollee and 53 prescriptions filled per Enrollee.

PERIODIC REASSESSMENTS

Our CMs conduct reassessments at least annually, as well as upon Enrollee or representative request, upon change in needs or circumstances, or upon referral from a provider, caregiver, or social services agency. Using our proprietary integrated clinical platform, CGX, we 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 several primary routes for identifying changes in an ESHCN's condition that may trigger reassessment to determine any needed change in risk level or services:

1. Submissions of authorizations for inpatient care, private duty nursing (PDN), PPEC, or other specialty services
2. Change in an Enrollee's risk score based on our Medicaid predictive models, including Severity Score, risk of a non-emergent ED visit, and risk of developing opioid use disorder
3. ED encounters, when available
4. Notification from the Medical advice line team and BH Crisis Line
5. Notification from our pregnancy application partner, Pacify
6. Notification from a provider, the Enrollee, their family, or other natural or community supports

7. From CMs and CHWs, who provide their contact information to Enrollees and their supports, encouraging them to reach out upon a change in condition or another health-related event such as an inpatient admission

These notifications will prompt outreach by a CM (or a CHW when appropriate). After addressing any urgent care needs and ensuring the Enrollee is in a safe environment, the CM will re-assess whether a change in services is required. As needed, we will engage providers on the Enrollee’s MDT to recommend services to meet the Enrollee’s identified needs.

ENROLLEE ENGAGEMENT IN ASSESSMENT AND CARE PLANNING PROCESS

Recognizing the varied linguistic needs of ESHCN (including non-English speaking and non-verbal individuals), we understand the need to take extra measures to account for communication abilities and languages spoken. Our CMs have access to a variety of tools and resources to facilitate the assessment and care management process. 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 ensure an interpreter is present during all interactions. For Enrollees who are visually or hearing impaired, we take measures to facilitate full engagement in the care management process, such as the use of teletypewriter and braille. We also take the Enrollee’s reading level into account when providing any written materials or communications.

Approximately 1,600 Humana Kentucky Medicaid Enrollees are Spanish speaking.

Humana trains our CMs to apply person-centered planning and motivational interviewing techniques to facilitate full engagement of the Enrollee and their support system in the care planning process. The CM works with the Enrollee, their Legally Authorized Representative (LAR), and identified support systems to agree upon a convenient day and time to complete the Enrollee Needs Assessment, allowing ample time for discussion.



Enrollee Story Spotlight:

Nancy, a 46-year-old Humana Enrollee living in Bowling Green, Kentucky, was contacted by a Humana CHW, Mike, to help her close care gaps related to her diabetes diagnosis. In addition to having diabetes and hypertension, she was also recovering from SUD, had recently lost both of her parents, was having trouble with her vision and teeth, and faced housing instability.

Mike contacted a Humana Kentucky Medicaid CM to engage Nancy in our Complex Care Management program. Mike and her assigned CM worked with Nancy to connect her with a PCP and ophthalmologist and coordinated with our dental and vision service provider, **Avēsis**, to help Nancy obtain glasses under our value-added service, as well as dental care. They also connected Nancy with Hosparus Health for grief counseling related to the recent loss of her parents.

Mike and Nancy’s CM also worked with a Humana Housing specialist to find Nancy low-income housing. With the help of Humana’s Kentucky Medicaid CCS team, Nancy engaged with her PCP, found housing, and is on her way to a healthier future.

b.iii. Approach to providing education to Enrollees and caregivers.

At the heart of our Enrollee education efforts is a commitment to helping people achieve their best health and lifelong well-being. We focus on creating personal, simple, connected experiences to help Enrollees and their families understand how to successfully navigate the healthcare system and make educated decisions to improve their health outcomes. We inform our education efforts by developing a deep understanding of the

communities we serve and by establishing and maintaining a 360-degree view of our Enrollees. We offer education via phone, digital platforms, in-person, or mail to meet the diverse needs of our Enrollees and their caregivers. Humana recognizes that each Enrollee has unique preferences, learning styles, literacy levels, and access challenges.

Our approach to education for ESHCNs relies on Humana associates and providers who have direct and regular contact with our Enrollees and are reliable and trusted sources of information at critical junctions in care. Humana will deploy the following approaches to provide education to Enrollees and caregivers.

CMs: For ESHCN and Enrollees with complex healthcare needs, ongoing interactions with our CMs form a deep understanding of Enrollee goals and needs, as well as necessary and beneficial supports and services. This relationship with our Enrollees enables CMs to supply personalized information that addresses Enrollees' unique needs, such as how to access services (including those supplied by a third-party payer) and the value of preventive and screening services. CMs engage Enrollees by providing symptom management, medication support, emotional support, behavior change guidance, and active PCP coordination. In line with our CCS team model, Humana's CMs also provide management of chronic conditions, maintaining the single point of contact for any Enrollee receiving care management rather than requiring them to receive support from multiple associates.

PCPs: Humana recognizes that PCPs are often Enrollees' most trusted source of health education and information. For ongoing educational purposes, we have partnered with **Relias** to provide an educational e-learning library to improve individual knowledge gaps and identify critical issues for improved outcomes, which we also offer to our CMs and other internal care supports. We equip PCPs with extensive health education and program information about the management of chronic conditions that enables them to educate Enrollees during their office visits. We hold education sessions at our PCP offices, focusing on specific topics or Enrollee needs. We also train our PCPs and their associates to assist ESHCN in accessing the educational materials and tools available on our website, as well as value-added services such as myStrength and Pacify.

In addition, Humana has entered into a partnership with **Bounce Coalition** to train Humana CMs and CHWs on ACEs and trauma-informed care (TIC), as well as with **University of Kentucky (UK) HealthCare**, as mentioned below. We believe this support will not only improve the quality of care and outcomes of our Enrollees who have experienced ACEs but will also enable our network providers to deliver educational content to these Enrollees that takes into account their history and needs.

**Humana–UK HealthCare Partnership:
Provider Training on TIC**

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 secondary traumatic stress-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 evidence-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

CHWs: CHWs are available to provide face-to-face support, including providing education and accompanying Enrollees to appointments.

Peer Support Specialists: Humana will work with community-based providers (e.g., CMHCs) to leverage their existing pool of Peer Support Specialists for our Enrollees with BH conditions and their families as recommended. **Humana will provide scholarships to train up to 50 Peer Support Specialists.** In addition to improving the availability of BH services in Kentucky, we anticipate that this investment will also lead to long-term employment and self-sufficiency among participating Enrollees.

Health applications: Through **KidsHealth®**, Humana offers our Enrollees access to a library of video and written content on pediatric BH and physical health conditions. We have designed KidsHealth content to be accessible and readable by children, adolescents, and adults, enabling our younger Enrollees to play a role in the self-management of their healthcare. In addition, our CMs use Humana's **Healthwise** system to deliver disease-specific education and self-management support to both adults and children.

Health education events: Through our **Kentucky Medicaid Community Engagement team**, Humana offers events to provide health education to communities throughout the Commonwealth, like participating in back-to-school events, setting up informational tables and providing resources at food pantries, and hosting community Baby Showers. In 2019, Humana had an average of 17 Kentucky Medicaid Enrollees attend each of our baby showers. We are excited to continue hosting baby showers across the Commonwealth for groups of expectant mothers upon Contract award. At these events, we will provide a healthy meal, present education through an interactive game, host community partners to present on important topics (e.g., how to install a child safety seat) and provide needed items to our Enrollees, and offer peer education opportunities for fathers-to-be. In 2018, through our work with the **Louisville Health Advisory Board**, Humana helped train more than 2,200 individuals on the Question, Persuade, Refer (QPR) method to help individuals experiencing mental health crises.

Proactive messaging and outreach: We use **our clinical rules engine, Anvita**, and predictive algorithms built around **our clinical technology platform, CareHub**, for targeted clinical messaging to Enrollees. Topics include the importance of annual well visits, vaccinations, mammogram reminders, and diabetes screenings. **Humana's state-of-the art, award-winning Customer Relationship Management (CRM) tool** gives a 360-degree view of the Enrollee by integrating more than 90 separate data sources, including CareHub. We use our CRM tool to personalize our Enrollee messages to include topics most relevant to them and to stay aware of what other communications they have received.

Community Partnerships: The Commonwealth of Kentucky is Humana's home, and we serve more than 900,000 Kentuckians in plans across all 120 counties. In representation of our longevity in and commitment to the Commonwealth, we are investing in diverse CBOs throughout Kentucky, expanding access to a wide range of service and support options. We have established formal partnerships with select CBOs throughout the Commonwealth and have listed below those that we view as being of particular value in delivering education to our ESHCN and caregivers.



Individuals with chronic BH needs

Humana will sponsor a school prevention program in pilot schools in Kentucky areas with high SUD diagnoses or overdoses. We are currently exploring a Drug Free Clubs of America model, which includes club membership ranging from approximately 10 to 100 students. We will also consider partnering with a local provider to offer free counseling to these students and their families.

Enrollees with pre-diabetes

Humana is partnering with Kentucky Primary Care Association and the YMCA to pilot an evidence-based lifestyle change program for the prevention of Type 2 Diabetes. Enrollees with a current diagnosis of pre-diabetes (and upon meeting other inclusion criteria), will be referred by their PCP and enrolled in the YMCA's Diabetes Prevention Program, recognized by the Centers for Disease Control and Prevention (CDC). Humana is tracking body mass index (BMI) change, weight loss, HbA1c change, and change in physical activity in minutes. The YMCA will collect data on food intake, activity, and weight at each session they attend.

Caregiver support

Humana recognizes the importance of caregivers for ESCHN, and the unique challenges and stresses that they face. We will therefore deliver specialized support to the caregivers of our Enrollees, with the aim of improving their well-being and reducing burnout. **Our Enrollee Needs Assessment includes an evaluation of the caregivers' needs**, their resources, and their ability to fully care for the Enrollee's needs, their involvement, and their level of decision-making. This survey – combined with ongoing engagement with our CMs and CCS team – guides the use of specialized educational resources for our Enrollees' caregivers. **MyHumana's Caring for Others** site provides resources and tips for caregivers to find the support they need to help their loved ones, including our **Caregiver's Toolkit**. In addition, we link eligible caregivers with available services through DAIL and Area Agencies on Aging and Independent Living, including the National Family Caregiver Support Program and the Kentucky Family Caregiver Program. We will also refer caregivers to resources such as the Family Caregiver Alliance and the National Center on Caregiving. Our CMs ensure caregivers are aware of those resources that Humana offers, including our Medical advice line and BH Crisis Line, both of which can support caregivers in the event of an unexpected challenge and support appropriate decision-making.

We have 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, quality, and access. Our care management associates will be engaged in the selection of Enrollees and caregivers to serve on the QMAC, ensuring that we can form a committee that is representative of our membership.

b.iv. Approach to providing transition support services.

TRANSITIONS FROM FACILITY TO COMMUNITY

For transitions from inpatient and residential facilities to the community, we follow the nationally-recognized Dr. Eric Coleman Care Transitions Model, which is grounded in improving quality and safety during transitions. At the foundation of our transition processes are the following five pillars of care, mirroring those of the Coleman Care Transitions Model:

1. Coordinated and proactive discharge planning, including communication among all stakeholders, referrals to needed post-discharge services, collaboration with CBOs, and timely and appropriate primary and specialty care follow-up post-discharge
2. Medication management and medication reconciliation during transitions
3. Establishing a medical home with a focus on prevention and proactive health management in the outpatient setting
4. Empowering Enrollees and their caregivers through education on their health conditions
5. Deploying a comprehensive staffing model to facilitate planning and transition; Humana's Transition/UM Coordinators are part of our CCS teams and work alongside our CMs and CHWs throughout an Enrollee's transition from one level of care to another

Pre-Transition

We begin to assess and plan for discharge needs upon notification of an admission. Along with reviewing the Enrollee's current clinical and functional status, we identify potential readmission risk using Humana's proprietary Readmission Predictive Model. Available on admission, the Readmission Predictive Model augments clinical review and helps identify Enrollees who may benefit from more intensive support across transitions of care. Transition/UM Coordinators review initial discharge planning information from the facility and work closely with facility discharge planning staff to identify and review potential barriers to discharge through communications with the Enrollee; their caregivers; LARs; and informal supports including PCPs, other acute and BH providers, the facility associates, Medicare or a State Agency CM (if applicable), CMs employed by BH

providers, and Prescribed Pediatric Extended Care providers to identify strengths and barriers to meet the Enrollee's discharge needs. If the Enrollee is dual eligible, enrolled in an unaligned Medicare plan, and engaged in Humana Medicaid care management, we request notification from their Medicare CM and the Enrollee upon admission so that we can support discharge planning.

Once they are engaged with the Enrollee and the facility discharge planning team, the Transition/UM Coordinator completes a comprehensive assessment of Enrollee and caregiver needs by completing the Discharge Planning Assessment in CGX. The Discharge Planning Assessment is a working document updated throughout the inpatient stay as additional information becomes available, up to (and including) the final facility discharge plan. The assessment gathers information on key factors that determine whether the Enrollee can be served safely in the community, including but not limited to:

- Medical needs at the time of discharge
- Potential barriers to discharge such as:
 - Confusion, cognitive impairment, and memory loss
 - Cultural or language barriers
 - Currently active BH diagnosis, including SUD
 - Diagnosis resulting in significant lifestyle change or educational needs
 - Homelessness
 - Environmental risk
 - Financial barriers
 - History of falls
- Behaviors and challenges such as:
 - Access issues, such as residing in a rural area
 - History of non-compliance with care plan or medications

Humana's Transition/UM Coordinators ensure the appropriate exchange of information to facilitate transitions to new settings or levels of care, including changes in medications and the discharge plan. We facilitate communication among the Enrollee and their acute care and BH providers to ensure needed services are in place at the time of discharge. This includes coordinating an outpatient appointment to occur within seven days of discharge for Enrollees discharged from an inpatient psychiatric facility. Humana's Transition/UM Coordinators and CMs (where applicable) provide referral and scheduling assistance both prior to and post-discharge. Prior to discharge, they also arrange authorizations for needed post-discharge services as ordered by the treating physicians, as well as referral and scheduling assistance with our home care partners.

Using a model currently applied to our Kentucky Medicare Advantage plan and Florida Medicaid plan, Humana will also place UM nurses onsite at high-volume facilities (with facility permission) across the Commonwealth to provide face-to-face discharge planning. This will facilitate personalized Enrollee care, individualized assessments to identify gaps in care and SDOH needs, real-time intervention and service coordination, a collaborative approach to Enrollee engagement, and improved provider relationships. Having this face-to-face support can also be crucial in discharge planning meetings to ensure the assignment of a Targeted Case Manager from the CMHC serving the Enrollee's region for Enrollees discharged from a psychiatric facility.

Post-Transition

Following the discharge, our Transition/UM Coordinators continue to provide referral and scheduling assistance to ensure follow-up provider visits and outpatient care are arranged according to post-discharge instructions. At a minimum, we administer a post-discharge call from our outbound call team or the Enrollee's assigned CM to check in on the Enrollee to discuss the status of discharge planning and remind the Enrollee of their upcoming outpatient appointment. We also assist with removing barriers to keeping appointments (e.g., by ensuring the Enrollee has transportation for follow-up visits). If indicated, we will assign a CHW to conduct a follow-up visit to the Enrollee's home to provide additional support.

For those Enrollees discharged from an inpatient psychiatric facility, Humana provides additional outreach and coordination. A member of our care management team contacts the provider and the Enrollee to ensure they have kept their initial post-discharge appointment. If they did not, our BH provider contract mandates that our BH network providers follow up with the Enrollee within 24 hours of a missed appointment. Our associates work with CMs assigned by BH providers to facilitate the discharge planning process and continuity of care following discharge for Enrollees discharged from a State-operated or State-contracted psychiatric facility or State-operated nursing facility for Enrollees with SMI. We have included more details about our processes for pre- and post-discharge support for Enrollees discharged from an inpatient psychiatric facility in our response to Section I.C.23 Behavioral Health Services of the Request for Proposal (RFP).

Recognizing the integral part that safe and stable housing plays in a successful transition, Humana's Housing specialist(s) and SDOH coordinators (a part of the CCS team) will support the CM and help the Enrollee live in the least restrictive setting of their choice. Humana will always honor the Enrollee's choice of housing whenever possible. As part of the transition process, Humana will support needed housing modifications by coordinating with community services. For Enrollees experiencing homelessness, Humana will provide targeted assistance through our medical respite model, as mentioned previously in our response to Section I.C.25.a of the RFP regarding innovative approaches to providing services to ESHCNs.

Enrollees with SMI Residing in Institutions or At Risk of Institutionalization

Humana participates in transition planning and continued care coordination for Enrollees with SMI who are transitioning from an institutional setting to the community. In compliance with Section 35 of the Draft Medicaid Contract, the Enrollee's assigned CM will perform a comprehensive physical, BH, and social needs assessment within 14 days of the transition. To perform this assessment, we review the Enrollee's person-centered recovery plan and level of care determination developed by the provider agency in tandem with our routine UM procedures.

TRANSITION FROM COMMUNITY TO FACILITY

When an Enrollee experiences a change in condition that indicates a need for facility admission (including inpatient, residential, and SNFs), a Humana CM coordinates with the Enrollee and their family to identify the right facility for the Enrollee's needs and goals, taking into account any geographic preferences when possible. Our CM works with the facility to complete admission paperwork (including the Preadmission Screening and Resident Review, as applicable) and to provide the Enrollee's care plan and assessment to the facility for review. In addition, our CMs provide their contact information to the facility staff to encourage communication and collaboration throughout the Enrollee's admission. We also stay in regular contact with the Enrollee per the contact frequencies appropriate for their risk level.

TRANSITION BETWEEN MCOS OR DELIVERY SYSTEMS

We recognize that ESHCN often have medical or BH conditions for which they receive specialty care. Interruptions in medically necessary care may have serious effects on their health and well-being. Drawing upon our experience caring for ESHCN in other states, we have designed our referral, coordination, and continuity of care system to ensure delivery of medically necessary care for these individuals.

Transitions out of Humana: When Humana is notified in advance that an ESHCN will be transitioning to another health plan or delivery system (including foster care and adoption assistance Enrollees transitioning to Kentucky SKY), our CMs will provide the Enrollee's medical history, existing PAs, and any active courses of treatment, along with the Enrollee's care plan, Enrollee Needs Assessment, and the Transition of Care form prior to the transition. We share this information with the next health plan, DMS, DCBS, or other entity responsible for the Enrollee's care (upon request). In addition, our CMs will offer to assist in the selection of a new PCP and coordinate the exchange of information between PCPs, including making the Enrollee's medical record available to the new PCP in accordance with applicable State and federal laws and with Enrollee consent.

When an Enrollee terms their enrollment with Humana without notice, their CM or a member of our care management team conducts outreach to the Enrollee/guardian and the Enrollee's provider to determine to which health plan they transitioned. If the Enrollee is at an inpatient facility at the time of transition, Humana will cover the cost of care until discharge.

Transitions for Enrollees in Nursing Facilities (NF): When an Enrollee enters an NF, their CM will coordinate with the facility to provide appropriate information for the required level of care determination, including previous care plans and assessments. If the Enrollee is determined to be eligible for long-term care, the Enrollee's CM will actively assist in the transfer of care to DMS upon disenrollment from managed care at the end of the month, including providing historic Enrollee data. Humana will continue to cover ancillary, physician, and pharmaceutical charges during the transition period.

Transitions for Enrollees Participating in 1915(c) Waivers: As with Enrollees eligible for LTC, Humana's CMs work with DMS, the Enrollee, and their caregivers to transfer care plans, assessments, and other relevant information, to provide a smooth transition for the Enrollee upon loss of Medicaid eligibility.

Transitions into Humana: When a new Enrollee joins Humana, we apply the identification methodology (including the HRA) described above to determine if they qualify as an ESHCN. If the identified Enrollee agrees to participate in care management, a Humana CM administers an Enrollee Needs Assessment to evaluate their need for additional support. The CM also assists the Enrollee in transferring their care to Humana, working closely with the Enrollee, their support system, their MDT, and in- and out-of-network providers to prevent gaps in care and ensure the Enrollee's needs are met during the 90-day continuity of care period and beyond. If the ESHCN is engaged in care management, their CM also requests historic data from their previous health plan and providers to inform the care plan and coordinate authorizations for needed services.

If the transitioning Enrollee wishes to remain with their current out-of-network (OON) PCP, specialist, or BH provider, our Provider Contracting team will reach out to the provider to initiate contacting procedures. We engage OON providers who serve new Enrollees and bring them into our network. Should a provider refuse participation in Humana's network, we attempt to secure a single case agreement with the provider to supply the Covered Services through the continuity of care period. We consider the availability of in-network providers who can meet the Enrollee's needs, including any language and cultural considerations, and Enrollee conditions that may necessitate ongoing care by their OON provider prior to the issuance of a single case agreement.

Supporting Transitions from Correctional Facilities to the Community

Acknowledging the barriers to accessing BH services that incarcerated Enrollees face upon release from prison and the higher risk of recidivism if they are not connected to appropriate care, Humana supports the Commonwealth's **re-entry pilot program** by providing integrated care management services to our Enrollees recently released from a correctional facility. Humana actively supports this collaborative pilot between DMS, the Department for Behavioral Health, Developmental and Intellectual Disabilities, and the Department of Justice (DOJ) to support recently incarcerated individuals and looks forward to continuing this collaboration as the Cabinet for Health and Family Services and DOJ expand it to new correctional facilities this year. Humana supports this program by ensuring that our Enrollees are immediately connected to a dedicated care manager, a PCP, and a community mental health center upon their release from prison. Humana has **designated a CM who is responsible for outreach to all recently incarcerated Enrollees identified under this pilot**, ensuring that our Enrollees are served by someone knowledgeable and familiar with the circumstances of their release and the systems available to support them. Our CMs ensure the Enrollee has all relevant Enrollee materials, understands all aspects of their plan, and receives services and prescribed medications, with the ultimate goal of preventing re-entry into a correctional facility.