D.	**Implementation Plan**

1.	Describe the Vendor's proposed approach to support the readiness review process, and include the following information:

Our extensive experience implementing Medicaid Managed Care and related programs, such as Medicare Advantage (MA) and TRICARE, and our incumbent status serving Kentucky Medicaid Enrollees greatly bolsters our ability to effectuate a successful readiness review process. This experience applies both to developing completely new plans and implementing new or adjusted elements of existing plans. Our approach to support all related readiness review processes is based on high levels of collaboration with the Department for Medicaid Services (DMS). Once the scope of the review is defined, we will identify a team of subject matter experts (SMEs) for our Operating team who will be responsible for ensuring our cooperation during the entire readiness review process and provide DMS staff with easy access to our associates, systems, and information. Our Kentucky Medicaid Chief Executive Officer (CEO), Jeb Duke, will lead the Operating team and will ensure that DMS has an identified, single point of contact during the entire readiness review process. While our existing operations will require modification to incorporate the programmatic changes required with the Draft Medicaid Contract (which may include system changes, hiring of new personnel, and additions to our provider network), we have already identified these modifications and are working to make the necessary changes. We have outlined our specific program updates in **Attachment I.D.1-1 Proposed Program Implementation Plan**. These are based on programmatic changes and proposed Humana commitments and innovations, including establishing our Medical Respite Program, Eviction Diversion Program, and launching our Workforce Development program. Because each implementation is unique, Humana commits to working closely with DMS to develop congruent systems, processes, benefits, and relationships to meet the Department's requirements.

a.	A proposed Program Implementation Plan beginning from Contract Execution through ninety (90) days post go live, including elements set forth in the Contract, such as: i. Establishing an office location and call centers. ii. Provider recruitment activities. iii. Staff hiring and a training plan. iv. Developing all required materials. v. Establishing interfaces to other Information Systems operated by Subcontractors, the Department, or others as required.

Attachment I.D.1-1 describes our Proposed Program Implementation Plan.

IMPLEMENTATION APPROACH

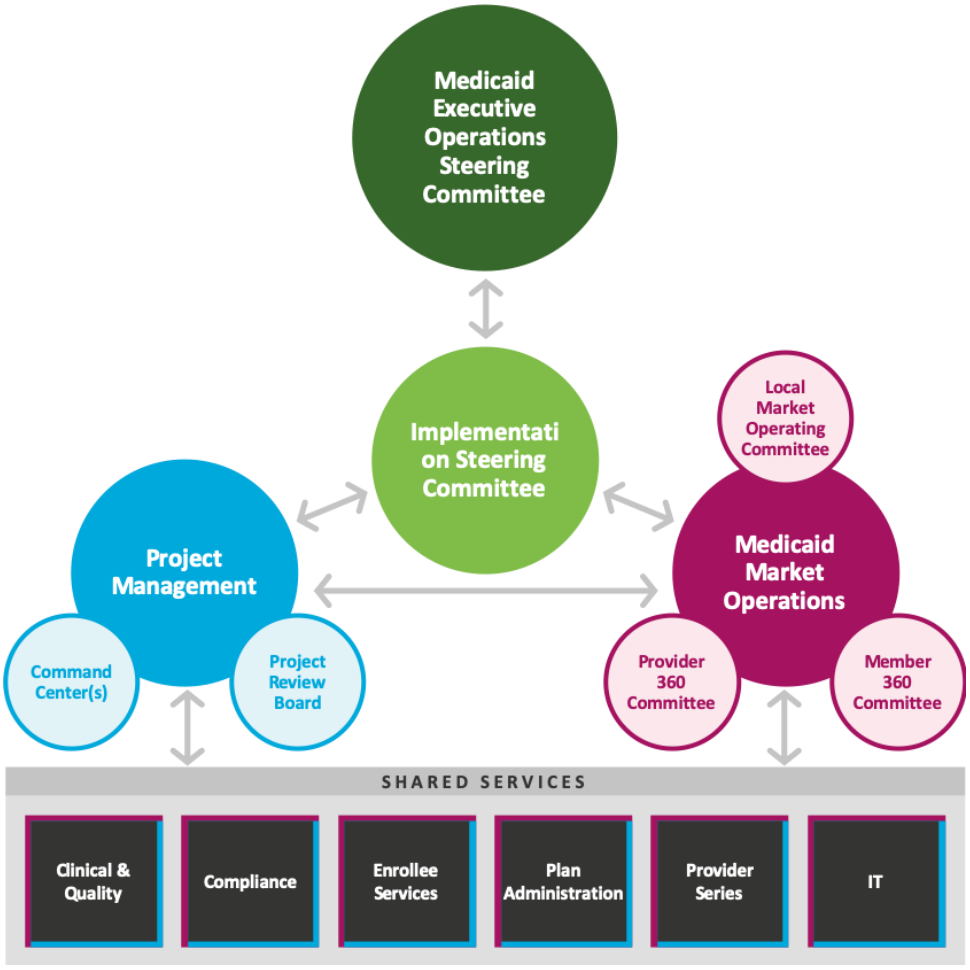
Humana's approach to project management and implementation applies industry standards, methodologies, and practices established by the Project Management Institute (PMI) Project Management Body of Knowledge (PMBOK) to effectively measure and control the quality of the products we develop. Humana's established Project Management Playbook, detailed below, defines repeatable processes that drive implementation and ensure consistency in process and quality. In addition to this Playbook, our well-defined Oversight and Governance structure also ensures success in effective project management and implementation.

Humana's Medicaid Governance Model

Humana's Governance Model, shown in **Figure I.D.1-1**, fosters coordination, communication, and collaboration across Corporate, Market, and Consumer and Provider Service and Solutions (CPSS). This model provides the structure to:

- Establish teams at all levels of the organization to support Medicaid growth and the implementation of new and renewing Contracts
- Ensure programs are executed against all aspects of the Draft Medicaid Contract
- Align strategic goals and objectives
- Organize communications between business sectors in Humana to ensure cohesion to the stated goals and objectives
- Facilitate cross-operational sharing of key projects, activities, risks, and issues

Figure I.D.1-1 Humana's Medicaid Governance Structure



The **Medicaid Executive Operations Steering Committee** will comprise the Medicaid Executive team across all markets and will provide support and oversight for both implementation and operations. This forum allows our Medicaid market leaders, CEOs, and other key executives to collaborate on key issues such as lessons learned, operational improvements, and strategies that will drive improvement across the program.

The **Kentucky Implementation Steering Committee** will meet weekly to track progress during program implementation and for at least 90-days post go live to identify issues, develop and assess resolutions, and offer risk mitigation strategies. This team includes Kentucky Medicaid CEO, Jeb Duke, Kentucky Project Manager, David Rosa, implementation team associates from all operational areas, business team leads, Information Technology (IT) leaders, and business development associates. The Kentucky Implementation Core team meeting is led by Mr. Rosa and consists of approximately 200 SMEs and project managers from across the company. These associates fully support every necessary function across the enterprise and are invaluable to the day-to-day implementation, planning, readiness support, etc.

Medicaid Market Operations: Our **Member 360 Committee's** seeks to identify ways to improve the Enrollee experience. Led by Herb Ellis, the committee meets monthly to review all metrics applicable to Enrollees, including grievance and appeals data, and provides a forum for review of Enrollee-related metrics, root cause analysis, process improvement opportunities, and escalation of Enrollee concerns. The committee includes representatives from all operational areas.

Our **Provider 360 Committee** is a cross-functional team chaired by Humana's Provider Services leader, Mary Sanders. The committee meets monthly to review provider trends related to claims, use of Availity (Humana's secure provider portal), quality metrics, grievances, and other provider inquiries. The committee includes representatives from our Claims, Grievance and Appeals, Credentialing, Provider Services, and Utilization Management (UM) departments.

Humana's **Local Operating Committees** (LOC) are market-specific and are comprised of the leadership team responsible for the day-to-day operations of the market. This team is in place today and will interface with the Operating team during the implementation of the new Contract. The LOC is responsible for resolving and escalating issues and risks through the Medicaid Governance process as needed. For new business, the LOCs begin 60-days post go live and continue indefinitely.

Project Management: The **Command Center**, which is comprised of our Operating team and additional operational SMEs, focuses on critical and high-risk issues related to implementation and those six months post-implementation. The Command Center provides a platform for cross-functional teams to connect and collaborate on issues and develop resolutions. Our Operating team triages and prioritizes issues based on impact to the Commonwealth and to our Enrollees by assessing the urgency of how much the incident affects Humana's operations or our Enrollees' ability to access care. The Command Center will support the program implementation effort through four key functions:

1. Identifying and escalating operational issues and risks and assigning resources to each issue or risk to ensure resolution; items are discussed at each daily meeting until resolved
2. Validating go live preparedness via a readiness checklist and oversight of business readiness validation
3. Tracking Enrollee processing during transition and service level agreement (SLA) compliance
4. Monitoring data feed transmission and controls/balances.

The Command Center maintains its function throughout the entire period of the new Medicaid Contract to ensure operational swiftness. Command Center meetings will occur daily up until after the 90-day period and when circumstances allow (this will be based on the decreased volume of discussion points), meetings will then occur on a weekly basis.

The **Project Review Board** (PRB) provides overall vision and direction, clears major obstacles, and sets priorities for IT projects. They liaise with management teams across all business lines to develop and prioritize IT projects. The PRB reviews and approves required project deliverables (e.g., Project Charter, Operating Model, Communications Plan, Resource Planning, Implementation Plan/Timeline, Vision, Scope, and Request (VSR) document, Post-Deployment Transition and Operational Hand-off Plan, and Project Closure Checklist) and serve as quality control and assurance for the Project Management Organization (PMO) process. Lastly, they monitor and provide weekly reporting on the status of the portfolio of Medicaid projects.

Implementation Project Management Playbook

Leveraging our experience from previous implementation efforts, Humana has developed a Medicaid Implementation Project Management Playbook that guides Implementation and Project managers along with the project team associates throughout the implementation process. Humana's Playbook provides a framework for:

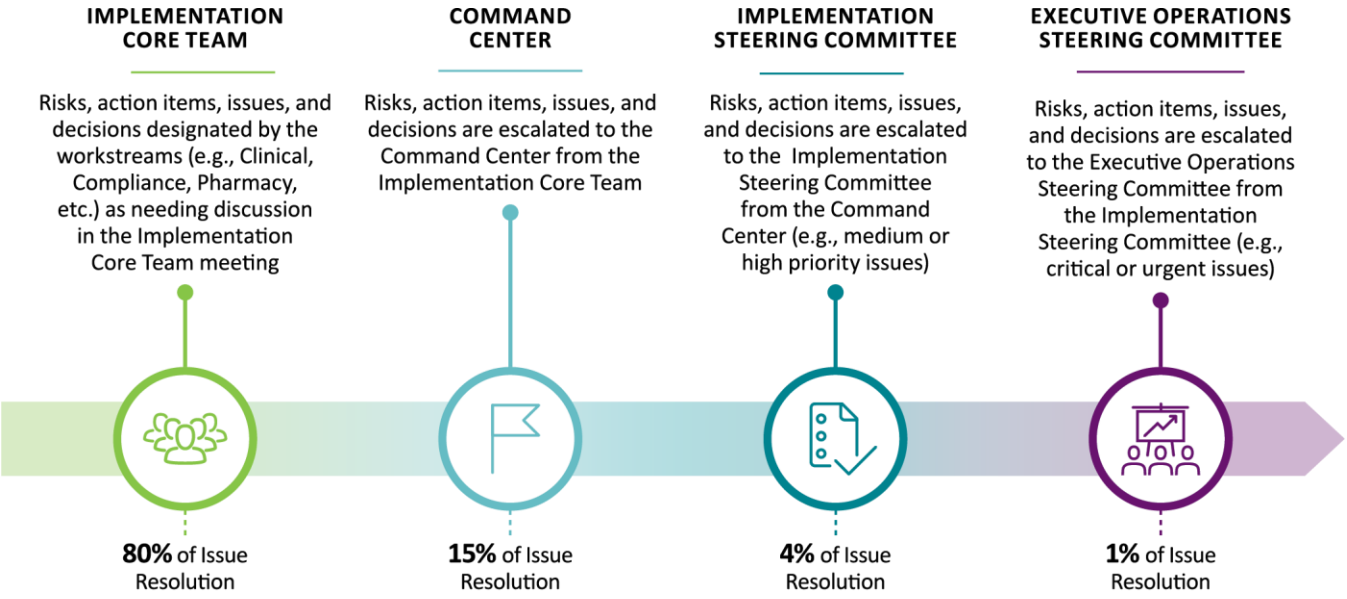
1. Developing a consistent approach to prioritizing, planning, approving, executing, managing, and tracking programs
2. Testing IT and Business Readiness

3. Developing Medicaid-specific requirements and general functional areas to consider during implementation, readiness review, go live, and operations
4. Communicating effectively with DMS to ensure we successfully address all Commonwealth-specific requirements and needs, including introducing best practices into our readiness review process
5. Communicating effectively with other MCOs and providers to ensure Continuity of Care and to foster a seamless transition for Enrollees

Ensuring Effective Internal Communications

Continuous and effective communication is crucial to a successful implementation and is a part of Humana's Project Management approach and Playbook. Our structured communication plan ensures communication is coordinated across all levels of the organization. This communication structure, in conjunction with our additional Project Management tools and work plans, allows us to quickly and effectively mitigate issues and risks. **Figure 1.D.1-2** depicts ours steps in escalating implementation concerns.

Figure I.D.1-2 Medicaid Governance Escalation Path



All risks, issues, action items, and decisions are managed through a consolidated RAID Log to facilitate transparency, accountability, and oversight.

Given the cross-cutting nature of our governance structure, any implementation and operational issues and fixes we identify are evaluated across all our Medicaid contracts. We use this same approach to communications with DMS ensuring we establish and maintain clear channels of communication and escalate all risks as necessary.

Business Readiness Validation

Humana will conduct a business readiness validation process during the final months prior to implementation of the new Medicaid Contract. This process is a critical validation step that Humana approaches in a carefully thought-out manner to identify potential risks, particularly related to Enrollees' transition and continuity of care arrangements, prior to implementation. Humana's experienced associates will develop scenarios based on actual Enrollee cases and input from the Commonwealth. The scenarios include applicability to providers, subcontractors, Enrollees, and DMS. We test these scenarios to identify problems and develop solutions to incorporate into our implementation processes before they occur.

OFFICE LOCATIONS AND CALL CENTERS

Humana's national headquarters have been located in Louisville, Kentucky, since our founding in 1961, giving us a longstanding and deep-rooted presence in Kentucky and a thorough understanding of the nuances of the Commonwealth and its populations. **We employ more than 12,500 associates in our Louisville offices, many of**

whom are Kentucky natives. Our local Kentucky Medicaid Market Office and both our Member and Provider Services Call Centers are located in close proximity to our Corporate headquarters in Louisville. Because our associates live and work locally, they have a deep and contextually informed understanding of the Enrollees we serve. In addition to the local presence of our corporate offices and call centers, we have established Humana Neighborhood Locations in Louisville and Covington. These local centers provide in-person customer service, health education, chronic condition classes, fitness classes, social activities, in-center screenings, and community resource referrals to our Enrollees and the community. In 2019, our Louisville location hosted **21,286 unique visitors, with more than 2,000 of whom were Humana Enrollees**. Our existing call centers and neighborhood locations effectively serve our current Enrollees and are scalable in response to potential enrollment growth upon Contract award and implementation.

PROVIDER RECRUITMENT ACTIVITIES

Humana's current provider network is in compliance with the access and adequacy standards set forth by the Draft Medicaid Contract. We contract with providers throughout the Commonwealth, including **100% of acute care hospitals, Federally Qualified Health Centers (FQHC), and Community Mental Health Centers (CMHC), and 94% of Rural Health Clinics (RHC)**. Our Kentucky Medicaid Primary Care Provider (PCP)-to-Enrollee ratio is approximately 1:33. While we currently provide a robust network across the Commonwealth to our Enrollees, Humana is committed to continuous network improvement.

Improving Access to Care Strategies: We will seek opportunities to increase access and adequacy standards for our Enrollees, with a special emphasis on areas such as behavioral health (BH) and specialty care. In addition, we are very in tune to access challenges in underserved areas; our Medicaid Leadership and Network Contracting team continually seeks opportunities and innovation (i.e., telehealth) to improve access to care in these areas. In particular, we are working to develop partnerships targeted at increasing access to PCPs, OB/GYNs, mental health providers (including SUD services), and dental services.

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

We offer telehealth and remote monitoring to support providers, particularly those in rural counties, to improve collaboration with Enrollees who are difficult to connect to care. Our telehealth solutions include:

- Telepsychiatry: Our partnership with Arcadian Telepsychiatry brings a virtual telemedicine platform that allows PCPs to connect Enrollees with BH providers via telephone, website, or mobile application whenever the Enrollee requires services.
- Diabetes mobile health application: We have partnered with WellDoc to access its diabetes mobile application, BlueStar, to address clinically proven dimensions of diabetes management. BlueStar connects Enrollees and their care teams through two-way chat functionality and supports clinicians through clinical decision support tools and a population management dashboard.
- MDLIVE: We will leverage MDLIVE's virtual care platform to offer our Kentucky Medicaid Enrollees telemedicine capabilities aimed at reducing emergency department (ED) visits. Enrollees will have access to a) Urgent Care through which they can access licensed healthcare professionals for diagnosis and treatment of common ambulatory illnesses, and b) BH and well-being services through teletherapy and telepsychiatry where Enrollees can see a licensed therapist face-to-face from the comfort of their home.

OB/GYN Providers: Humana's network includes 736 unique OB/GYN providers, inclusive of maternal and fetal medicine specialists. Our Provider Relations representatives regularly visit and communicate with OB/GYN offices to educate providers on our maternity care management program, MomsFirst. Our MomsFirst, Neonatal Intensive Care Unit (NICU), and incentive programs provide additional support to our network OB/GYN providers in the monitoring and care of our pregnant Enrollees.

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

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

STAFF HIRING AND TRAINING

Upon Contract award, each Humana associate will go through a thorough and rigorous training on the nuances and requirements of the new Contract. Each department, including program integrity, claims and encounters, population health, utilization management, quality, clinical, and provider network will receive specialized departmental training.

Enrollee Services Training: Humana employs a variety of training methods to prepare our call center associates to serve our Kentucky Medicaid Enrollees, including classroom training; online training with live video interactions; individualized hands-on training; job shadowing with an experienced associate; and an immersive, interactive simulation that helps our call center associates understand the daily living challenges facing our Medicaid Enrollees. Humana associates receive updated trainings upon onboarding and annually thereafter. At a minimum, we cover the following topics:

- Commonwealth requirements and Covered Services
- Fraud, Waste, and Abuse (FWA) and Ethics
- Cultural competency
- Supporting Enrollees with BH diagnoses
- When to refer Enrollees calling the Member Services Call Center to our Medical advice line, BH Crisis Line, or care management

Each Member Services Representative (MSR) will also receive a tailored set of monthly training modules based on knowledge gaps or performance improvement areas identified during their monthly performance review to complete. We will also conduct training for all MSRs when new Contract requirements or Member Services Call Center trends dictate a need for additional education.

Our MSRs will have access to resources that can help them serve our Kentucky Medicaid Enrollees, including:

- **Mentor**, a Humana-developed knowledge management system that contains instructions for guiding Enrollee interactions, including best practices on how to manage difficult calls

- **Teletypewriter**, video relay, and interpretation services for associates to communicate with those who are hard-of-hearing or who prefer to communicate in a language not spoken by our MSRs
- **Customer Relationship Management** (CRM) system, an integrated Humana system that helps MSRs supply tailored guidance and support to Enrollees, including the name and contact information for their Care Managers (CM), risk stratification level, and information on past claims
- **Clinical Guidance eXchange** (CGX), our integrated clinical platform. Through CGX, MSRs can view Enrollees' care plans, service histories, and communication history
- **Avaya** call center solution, an intelligent technology platform rated at more than 99% for reliability and redundancy, seamlessly routes calls to the appropriate call center associate in the most efficient manner
- **Mattersight** records calls for call events such as an expression of distress by an Enrollee and a corresponding expression of empathy or positivity by an MSR. Our Quality Assurance (QA) team can also search for phrases like "I don't know" to evaluate calls. Our team assigns the call a rating based on factors such as length of the call, hold or silence time, and words expressed.
- **Watson** allows callers to have a conversational dialogue with an advanced artificial intelligence (AI) agent and provide feedback on the experience. The AI agent inquires on caller needs, engages in dialogue to determine intent, obtains the needed information from Humana systems, and then relays the answers in conversational language. Humana has been programming and training Watson to streamline the process for providers so that they can efficiently get the information that they need for eligibility, benefits, authorizations, and claims status rather than spending their time navigating an Interactive Voice Response (IVR).

Provider Services Training: Our core training curriculum is developed by our National Education and Policy Development team, which works in consultation with leaders from our Provider Services Call Center, Provider Relations, and Provider Network teams. We regularly refresh the training curriculum to address opportunities identified through our performance metrics, program updates, grievances, and other feedback loops. We will refresh the training to incorporate new contractual and programmatic requirements. We have a multi-phased training process for Provider Call Center Representatives (PCCR) that includes ongoing monitoring of live calls to identify individual performance issues and retraining opportunities. Because we require all PCCRs to be retrained annually or more frequently as needed to address changes in operations, programs, or performance, we will retrain all our PCCRs regarding the Draft Medicaid Contract prior to the January 1, 2021 go live date.

DEVELOPING REQUIRED MATERIALS

We use a thorough multi-level review process to ensure our materials comply with State requirements and are designed to best meet our Enrollees' needs. First, our Medicaid Communications team coordinates an enterprise-wide review. At a minimum, this review includes our Experience, Strategy and Transformation team (ESTT); experts from our marketing, clinical, and quality organizations; and our Kentucky Medicaid Market leadership team. These teams review all materials for accuracy, quality, and completeness. Once this review is complete and we have made any needed updates and adjustments, our Contract Management, Regulatory Compliance (RC), Product Compliance, Legal, Privacy, and Risk Management departments complete a final review of the material. Upon completion of these reviews, our Medicaid Product team submits the materials to DMS for review and approval.

ESTABLISHING INTERFACES

Humana has considerable experience establishing and maintaining electronic interfaces with DMS and its contractors, the Centers for Medicare and Medicaid Services (CMS), and other regulatory bodies to ensure accurate and timely data transmissions. Humana's Electronic Transmissions department, whose sole function is to fulfill inbound and outbound data feeds from our systems, ensures we take all appropriate security measures to protect the data and monitor the data feeds in the operational steady state. New data feeds will be subject to all applicable System Development Life Cycle (SDLC) disciplines. In addition, Humana will work closely with DMS to establish necessary connectivity with the appropriate testing environments that DMS uses to test connectivity

and functionality. Through systematic data exchange tests, Humana will submit test transactions (if requested) that meet DMS's processing specifications. We will then review detailed information on errors for correcting files, resubmit test transactions as needed, and track testing activity with online utilities.

b. Proposed staffing to support implementation activities and readiness reviews.

Our current staffing levels effectively support smooth operations for the existing Contract. **Humana employs more than 12,500 Kentucky-based associates**, ranging from call center associates to corporate management, who serve our current Kentucky Contract. **We will employ more than 582.1 full-time equivalents (FTEs) for the new Contract**. For additional information on staffing please refer to our response in section I.B.3.

For the new Contract, our Implementation team leader, Cathy Stull, will use the Operating team to define the implementation plan and identify any programmatic changes and expanded membership that will require supplemental staffing and resources for readiness review. We will also utilize robust resources from our existing Medicaid Implementation team to support discrete areas during the Implementation and Readiness Review. In addition to the expertise that our corporate teams, Shared Services teams, and local Kentucky market bring, our Implementation team is comprised of leaders with deep operational expertise across a variety of functions and who bring years of experience implementing Medicaid plans/programs. Additionally, Humana's **Contract Management Unit** (CMU), which leads the implementation of any regulatory changes published for Medicare or Medicaid, will lead the readiness review process and draw upon multiple corporate and market-based resources. Our CMU leads our regular internal and State/CMS required audits, affording them the expertise to effectively lead our teams through Readiness Review and ensure a favorable outcome and collaboration with DMS.

c. An overview of system operational implementation requirements and related milestones.

A Medicaid Implementation team leader directs the transition process guided by the implementation Playbook methodology, which Humana initially developed in consultation with leading industry experts, and has been updated based on Humana's experience with successive implementations, including traditional managed Medicaid and managed Long Term Services and Supports (MLTSS) programs in Florida, an MLTSS program in Illinois, and Financial Alignment Initiative programs (Dual Demonstration) in Illinois and Virginia. We have designed the Playbook to establish a repeatable framework for program management, use a common set of tools to drive projects to deliver Humana's strategic objectives, leverage prior experience, and focus on improving both communications within Humana as well as externally with the Department and subcontractors.

Readiness Review

- System Readiness Review: During our System Readiness Review we will provide the Department with data and process flows for system-wide functions as well as updated system plans (e.g., Disaster Recovery and Business Continuity). We can perform these demonstrations during in-person or via online sessions. We can demonstrate claims adjudication scenarios live and generate explanation of remittance (EOR) via a nightly batch process. Humana has processes in place to demonstrate capability readiness for end-to-end functionality. We also participate in the end-to-end trading partner testing for encounter data with DMS and can demonstrate encounter file feeds for specific scenarios during readiness reviews. Humana's Business Readiness Validation (BRV) (an intensive internal audit and review process) will supply end-to-end overviews of our capabilities, live demonstrations of the various user interfaces, functionality and processing, and live reviews of the Enrollee experience through Enrollee Services and portals, prior to commencing operations. **Recently, Humana successfully completed several rounds of readiness reviews with DMS agencies as we transitioned from Humana-CareSource to Humana only on January 1, 2020**.

- Operational Readiness Review: Operational Readiness Review will encompass our current operations of all activities and deliverables, including but not limited to, the Network Adequacy Plan, training curricula for Member Services Representatives and Provider Services staff, Enrollee information materials, Provider Manual, Enrollee grievance and appeals processes, FWA compliance plan, and care management procedures.

Network Development

Network development activities will include an assessment of our current network, which currently complies with the Draft Medicaid Contract's access and composition standards. Our Network Management team will identify any areas where we may provide innovative solutions to better serve Enrollees, particularly in underserved areas.

Post Transition Phase

Humana Kentucky operations will receive continued support from the corporate Medicaid Implementation team through the end of all required deliverables associated with the transition phase and develop document retention and disaster plans as related to the transition phase. The Command Center will identify, track, and resolve issues or gaps; assign ownership to identified risks/issues to put solutions in place; escalate issues to the Department; and develop communication plans.

Proposed Schedule

Figure I.D.1-3 below is a summarized view of our proposed implementation plan. Further detail on these milestones can be found in **Attachment I.D.1-1 Proposed Program Implementation Plan**.

Figure I.D.1-3: Program Implementation Milestones

Milestone	Start Date	End Date
Review RFP and Draft Medicaid Contract	1/10/2020	2/27/2020
Finalize Benefit Design Including Enhanced Benefits	7/1/2020	7/1/2020
Identify Impacts to All Business Areas	1/10/2020	3/15/2020
Finalize IT Requirements	11/1/2020	5/30/2020
Finalize Changes to Staffing and Hiring Process	4/30/2020	10/1/2020
Evaluate Existing Workspace and Build Out New Space as Necessary	5/1/2020	10/1/2020
Finalize Enhancements to Digital Presence	9/17/2020	9/19/2020
Finalize Enhancements to Clinical and Quality Model and Training	2/1/2020	9/15/2020
Determine and Finalize New Connectivity with State and Subcontractors	5/1/2020	8/15/2020
Finalize Changes to New or Existing Policies and Procedures for DMS Approval	5/1/2020	TBD at DMS Direction
Submit New Enrollee and Provider Materials for DMS Approval	TBD at DMS Direction	TBD at DMS Direction
Educate Provider Network on New Program	9/1/2020	12/1/2020
IT Enhancements Release to Production	9/17/2020	9/19/2020
Participate in DMS Readiness Review	9/15/2020	10/15/2020
Load Initial File for 1/1/2021	11/1/2020	11/3/2020
Send New Enrollee Materials	11/5/2020	11/5/2020
Create Go Live Command Center	12/1/2020	2/27/2021
Monitor for Post Go Live Risks and Transition to Normal Operations	1/1/2021	3/31/2021

d. Required MCO, Department, and other resources to ensure readiness.

Confident in our experience, team, and capabilities, Humana will ensure readiness and execute a collaborative readiness review process with the Department. Humana has already successfully passed multiple readiness reviews with the Commonwealth, and we anticipate following the same historical processes. Through our experience with DMS, we are confident in the processes and procedures we have developed to meet the Commonwealth's requirements. We will work closely with the Department and engage in face-to-face meetings to identify all necessary documentation, systems, and personnel needed to ensure readiness. Humana recognizes that each implementation is unique and has thus identified the following resources we will require to complete a successful readiness review upon new Contract implementation.

Humana Resources to Ensure Readiness

Humana dedicates significant resources to our implementation and readiness review process to ensure success. As previously detailed, our Project Management Playbook drives our implementation and readiness review and ensures consistency in process and quality. In addition, our well-defined Oversight and Governance structure assures success in effective program management and implementation. We use a readiness checklist provided by the Department as well as our own internal checklist to effectively track tasks by date and business owner, ensuring clear lines of responsibility and driving efficiency.

As mentioned in I.D.1.b of this response, we utilize an experienced Implementation team that will be engaged to support the larger core and executive teams. Led by Cathy Stull, these associates bring specialized and diversified skill sets and leadership capabilities spanning key functional areas. In addition to the expertise that our corporate teams, Shared Services teams, and local Kentucky market bring, our Implementation team is comprised of leaders with deep operational expertise across a variety of functions and who bring years of experience implementing Medicaid plans/programs. The Operating team will define the implementation plan and identify any programmatic changes and expanded membership that will require supplemental staffing and resources for readiness review. We will also utilize robust resources from our existing Medicaid Implementation team to support discrete areas during the Implementation and Readiness Review. These teams, which work closely with multiple functional areas and thus have gained an intimate understanding of critical functions and operations, will enhance the work of our CMU conducting the Readiness Review process.

To be fully prepared in advance of readiness review, our CMU conducts a re-review of the new Contract, the impact of all rules and regulations, and Contract requirements to identify any changes required of our policies, processes, and procedures. CMU associates participate in several oversight committees to further the sustainability of compliance with CMS and State Medicaid agency Contract requirements including the Regulatory Compliance committee, Medicaid Joint Compliance committee, and the Medicaid Operations Steering committee. In addition, the CMU leads our regular internal and State/CMS required audits, affording them the expertise to effectively lead our teams through Readiness Review and ensure a favorable outcome and collaboration with DMS.

Department Resources Required to Ensure Readiness

In our experience implementing Medicaid plans, we have learned a clear scope of work articulated from the Department is necessary for us to provide ready and sufficient resources to complete a thorough and efficient readiness review. From our partners at the Department, we would request a regular cadence of implementation meetings leading up to the readiness review to ensure that we can continue to strengthen our partnership and align on joint timelines, status reporting, and any policy decisions impacting MCO operations or administration of the new Contract.

Humana will require access to the Department's historical readiness review tools and tracking mechanisms and an understanding of any changes to the readiness review process for the new Contract. To ensure we retain the highest level of connectivity between Humana and the Commonwealth, we would also require a partnership with both DMS and the Office of Administrative Technology Services (OATS) to ensure continuity of care and

services. This would include refreshed versions of technology specification documents and companion guides. We would also request that the our valued partners at OATS meet with Humana Implementation and Technology leads on a regular cadence to allow for clarification of technology requirements, testing of any new file exchanges and security protocols, and general collaboration to continue building upon the foundation of our partnership.

2.	Describe potential limitations or risks that the Vendor has identified that may impact planning and readiness, and indicate the Vendor's proposed strategies to address those limitations and risks. Include examples of similar situations the Vendor has encountered with prior readiness planning and resulting solutions.

Humana understands the inherent nature of implementation presents unique challenges. While we strive for perfection, we recognize potential limitations or risks exist with new Contract implementation for which we must prepare to address. We have devised measured strategies, which are elucidated below, to proactively mitigate potential limitations or risks we anticipate encountering with the new Contract launch.

POTENTIAL LIMITATIONS OR RISKS AND MITIGATION STRATEGIES

We anticipate that the following components of the implementation may present certain challenges:
Electronic Verification Visits (EVV): We have found the direction concerning the application of EVV to Personal Care Services to be straightforward. However, the interpretation of which codes to include regarding Home Health Services varies from state to state with certain states like Florida allowing MCOs to use their own discretion and other states like Texas publishing a list of applicable codes. Our experience in Florida – where each MCO is permitted to select their own vendor – has unfurled multiple and differing processes and code level requirements across MCOs despite the majority of MCOs having selected the same vendor. This variability highlights the criticality of consistency and standardization to ensure success and foster efficiency. Provided this, we could encounter potential challenges if each MCO is permitted to select their own EVV platform and/or vendor.

Credentialing Verification Organization (CVO): While we do not believe the introduction of a CVO by DMS will pose insurmountable challenges, due to the integration and complexity, we have identified CVO implementation as a potential risk that requires cooperation with the Commonwealth and the CVO to effectively remediate.

Past Experience Managing Risk at Go Live
Our vast implementation experience has taught us the importance of starting the planning process as early as possible and with a wide array of SMEs across the enterprise. This approach ensures we identify risks early and mitigate accordingly. Aligning with this approach and based on past experience, we have already identified select subject areas (described below) that require additional focus prior to implementation. Due to this prioritization and our proactive nature, Humana has already begun to implement strategies to address these priority areas.

Proactive Strategies to Minimize Exposure to Prioritized Limitations/Risks:
Enhancing Current Technological Capabilities: Given the ever-increasing and rapid nature of technology, our current technological capabilities, which currently and effectively serve our Kentucky Medicaid Enrollees today, may require enhancements to meet new Contract requirements and commitments. We have multiple ways to mitigate potential issues throughout the Software Development Life Cycle (SDLC) such as combining testing efforts (e.g., system integration testing (SIT) and user acceptance testing (UAT)), running tests in parallel, and running off-cycle reassess through holding claims or disabling automation and reverting to manual processes.

Resource Onboarding: Increasing our resources to support the new Contract and respond to potential enrollment growth presents another potential challenge to successful program implementation. Our senior leadership is fully prepared to dedicate necessary resources by expanding incrementally to ensure adequate

staffing. Humana's Human Resources (HR) team is deeply integrated in the Commonwealth and will attend local job fairs, offer sign-on bonuses, and actively seek to onboard resources from exiting competitors to quickly meet the needs of the new Contract.

Ensuring Continuity of Care: Finally, ensuring Enrollees retain access to their current providers, even if they are out-of-network, at the point of program go live is a key priority area for Humana. We will ensure each new Enrollee has access to all current service plans and authorizations until we can effectively reevaluate in order to prevent any and all gaps in care. Humana will mitigate this potential risk by working closely with DMS and existing plans to ensure we receive pertinent health information on all transitioning Enrollees, including authorizations, care management information, and all services and providers on record. We will proactively load authorizations and onboard any non-par providers beginning with letters of agreement (LOAs) and moving to full contracts, as possible. In the unlikely event we cannot get a provider in-network, our associates will work closely with the Enrollee to find them an appropriate in-network provider. We will continue to pay the Enrollee's provider until an alternate is located and extend continuity of care timeframes.

SUCCESSFUL EXAMPLES OF PAST ISSUE/RISK MITIGATION

KY HEALTH Implementation

Technical System Requirements: In preparation for potential KY HEALTH implementation, Humana worked closely with DMS on a consistent basis for more than two years of development. During this innovative process, DMS and MCO system development was key to successful program development. Our flexible IT department adapted as needed to meet the evolving needs of the program. Humana worked with DMS to meet the needs of Production Integration Testing (PIT) and Dry Run Testing to ensure Enrollee needs were met. Our dedicated teams worked days, overnight, and weekends and facilitated many face-to-face meetings with DMS to successfully meet file requirements. This required multiple system environments to support the testing and production needs. Challenges included finding the most recent documents for guidance in the State repository, receiving timely responses to complete the necessary work, and coordinating effective channels of communication. We expanded our resources and staffing to track all changes, meeting notes, documentation and versions of guidance. **We successfully and consistently met deliverables during this intense collaboration with the Commonwealth**.

Readiness Review: In preparation for KY HEALTH, DMS performed a readiness review that identified issues preventing Humana from passing the initial review. Humana worked diligently to remediate these issues that involved revising our Benefit and Cost-Sharing Mapping, adding policies for Fast Track to the provider portal, and revising deductible statements to meet requirements supplied through DMS's Readiness Review Grid. We also increased collaboration with the Commonwealth, which allowed our IT, Operational, and Communications teams to meet the requirements for all items. Humana was approved to go live following a second readiness review.

Enhancing Communications: Our KY HEALTH development team experienced multiple fast-turn changes throughout the execution phase, presenting complications to effective communication with DMS, OATS, our partners, Enrollees, and providers. In response, we increased our internal communication efforts with all stakeholders through meetings using agile standup methodologies, dedicated resources focusing solely on KY HEALTH, and targeted, succinct daily communications to ensure full and open communications. **Humana facilitated and led MCO-only meetings during the requirements phase, which enabled all Kentucky plans to compile the weekly list of questions for DMS, simplified the question and response process, and saved money and time for the Commonwealth and each health plan**.

Upon go live of the new 834 enrollment file, we discovered an error in our outbound enrollment file to one of our major subcontractors. While we were able to perform root cause analysis and implement a hot fix within a day, this could have potentially caused an obstruction of valuable services to our Enrollees. Out of our lessons learned review, we identified and documented a series of file validations and repeatable/reusable subcontractor file exchange test cases and procedures to ensure we did not send out incorrect files.

Contingency Plans: The litigation in response to KY HEALTH uncovered a problem with contingency plans not being in place. With the judgement during the first go live coming just two days prior to the go live date, we placed a hold on all program implementation workstreams. Both the Commonwealth and MCOs experienced challenges in backing out the system changes that were already in production. The go live date occurred on a Sunday, which added to the complexity of reacting quickly to the court's decision.

Collaborating with the Commonwealth to get messaging out to Enrollees and providers and setting reasonable timelines to stop the system changes in place were critical in this pressured situation. Humana worked closely with DMS to notify all stakeholders and to support system changes impacting eligibility, billing, care management, and all other areas of KY HEALTH. For example, the first set of KY HEALTH premium invoices had already been mailed to Enrollees and payments had been made, which meant our systems held booked financial transactions and some Enrollees were effectuated into KY HEALTH alternative benefit plans in our enrollment system starting the first of the following month. We had also already begun to process Welcome Kits and Enrollee ID cards with our print subcontractors. We quickly unwound these processes and system changes, notified Enrollees, and made decisions about refunding premium payments. Success came after many calls and face-to-face meetings with the Commonwealth. **The lessons learned from the first implementation resulted in sound contingency plans for the second KY HEALTH implementation**. We successfully used the contingency plans put into place in the first quarter of 2019 when a similar court decision again delayed program implementation.

Humana-CareSource Transition

For the January 1, 2020 transition from the Humana-CareSource administration to Humana only, Humana was tasked with passing a Policy Readiness Review on October 24, 2019, and an IT Systems Readiness Review on November 7, 2019. While Humana successfully completed the reviews with DMS and OATS officials, there were additional follow-ups spawned from the supplied documentation and subsequent review questions. An example of this occurred regarding our clinical review criteria and process. As a result, Humana worked closely with DMS to review the specifics of our process and guideline criteria in order to resolve all outstanding questions.

As we began weekly meetings with the OATS team, we were informed of a need to connect with the Commonwealth through a Virtual Private Network (VPN) process. As we did not leverage this process as part of our Humana-CareSource administration, it would be a new setup, which required extensive setup time, security key exchanges with the Commonwealth, and testing to ensure connectivity. Humana met with OATS and their DXC partners for several months, and successfully passed three (3) rounds of testing in November to ensure a cutover date of December 2, 2019.

Florida Implementation

In Florida, Humana has been a valued partner of the State and recently invested significant resources to implement an expansion of our footprint to provide Medicaid across all 11 regions and covering more than 460,000 Enrollees after being awarded a statewide comprehensive contract by the State in 2018.

Systems and Operations Enhancement: To support a seamless transition to the new Contract and enrollment of a projected additional 130,000 Enrollees, we enhanced our existing capabilities, [redacted] to expand our Long Term Care networks, hire additional care management and clinical associates, and strengthen our management information systems (MIS). In total, **we added 287 FTEs to support the new Contract, enabling us to successfully manage the onsite readiness review and submit an Implementation Action Plan rated 94% complete on first pass by the Florida Medicaid State agency**.

Due to a high number of Enrollees transitioning to new plans, our initial enrollment growth was significantly higher than anticipated. While we prepared to expand our Member Services Call Center hours and staffing, we determined that we required even more extensive resources and staffing than expected. Further, we received more LTSS Enrollees than communicated and were forced to pivot our resources to increasing our CM associates. We immediately leveraged our on-the-ground resources to quickly and effectively recruit and train

additional CMs while ensuring that no staffing discrepancies affected our vulnerable populations or delayed their initial visit.

As a result of updates to contractually-required system capabilities, Humana quickly adapted our systems in such a way that allowed the functionality to be toggled on at an appropriate time, based upon when the functionality is needed to go live and when training has been completed. Humana's system flexibility enables us to be prepared for evolving Contract changes and new implementations.

Ensuring Strong Provider Engagement: Using input from our Provider Advisory Committee (PAC), we learned that providers sought a dedicated forum to learn more about the changes to Florida's Statewide Medicaid Managed Care program, as well as Humana's operations and expectations. To address this, our Provider Relations associates held provider town halls in every region of the State and, in certain areas, held multiple town halls, both virtually and in-person. Provider feedback indicated they found this to be a highly useful format, which we will replicate in the Commonwealth upon Contract award.