

C. Technical Approach

2. Collaboration (Section 9.0 Organization and Collaboration)

Strong relationships with the Kentucky Department for Medicaid Services (DMS), other healthcare and social service agencies, and other Managed Care Organizations (MCOs) are critical to achieve program goals and improve the quality of care for Enrollees. **Humana is committed to strengthening the partnerships we have developed over the last seven years serving Kentucky Medicaid Enrollees and over the last 59 years of calling Kentucky our national headquarters.** Establishing and regularly working to maintain and improve a strategic approach to collaboration between and among DMS, other agencies, and other MCOs will increase the quality of health plan interactions. This process will enhance transparency and improve planning for long-term objectives, which will help us collectively achieve programmatic goals.

a. Provide a recommended approach for conducting monthly meetings that the Vendor must attend with the Department, other agencies, and other contracted MCOs. In your response, provide the following, at a minimum:

a.i. Meeting formats the Vendor proposes that will result in successful collaboration.

Over the last seven years, Humana has appreciated DMS' willingness to collaborate through regularly scheduled meetings with MCOs, as well as with other agencies and stakeholders. We have found the following meetings are productive forums to collectively work toward targeted goals and objectives, and we recommend a continuation of these collaborative meetings. For the purposes of this response, our recommended meeting formats for conducting meetings with DMS, other agencies, and other contracted MCOs will focus on **Monthly One-on-One DMS-Humana Operations Meetings and Quarterly All-MCO Meetings**. While all interactions between and among MCOs, DMS, and other agencies offer opportunities to collaborate, these two meetings offer a more open-ended forum to best enable broad collaboration.

Current Kentucky Medicaid Collaboration Meetings

- Weekly
 - DMS Information Technology Meeting
- Monthly
 - One-on-One DMS-Humana Operations Meeting
- Bi-Monthly
 - Humana Encounters Meeting
- Quarterly
 - All-MCO Meetings
 - Department for Community Based Services (DCBS) Meeting
 - Program Integrity Meeting
 - Quality Meeting
 - Department for Behavioral Health, Development Intellectual Disabilities (DBHDID)
- Annual
 - DMS Provider Forums

ONE-ON-ONE HUMANA-DMS MEETING FORMAT

Meeting Description and Objectives

Regularly occurring one-on-one meetings between Humana and DMS should be used to align on short- and long-term strategic goals and translate those goals to tactical and measurable solutions. Within the first 30 to 60 days post-Contract execution, we recommend the meeting format focus on execution of the new Contract. Following successful implementation, the meeting's focus should shift to ongoing and long-term collaborative strategic planning and goal-setting. Upon mutual approval of the ongoing and long-term strategic objectives and tangible metrics, subsequent meetings should focus on tracking progress and setting new goals.

Meeting Format, Attendees, and Agenda

We recommend the DMS Medicaid Commissioner and Deputy Commissioner continue hosting monthly one-on-one meetings. DMS should invite other staff to attend monthly MCO meetings as available and appropriate. Humana's Kentucky Medicaid Chief Executive Officer (CEO), Jeb Duke, will attend all monthly meetings and take responsibility for providing updates on outstanding deliverables, with support from subject matter experts who have experience relevant to the agenda topics. To improve relationship-building between DMS and MCOs, we recommend requiring that all MCO attendees join the meeting in-person.

MCOs should be expected to propose agenda topics in advance, but DMS should maintain authority to define monthly meeting agendas. Agenda topics should include status updates for ongoing or long-term strategic programs, reporting on results from recently completed initiatives, and new issues that need near-term resolution. We recommend confirming meeting agendas 48 hours in advance to ensure productive and efficient collaboration among all parties. As appropriate, DMS and Humana may also establish ad-hoc or subgroup meetings to more narrowly address issues based on findings resulting from meeting initiatives.

Humana recommends the following agenda structure for each meeting:

- Approval of the minutes from the previous meeting
- Status review of outstanding and ongoing action items
- New issue review and associated action plans
- Assignment of new action items to responsible parties
- Adjournment

Tracking and Reporting

For each meeting, Humana's health plan CEO or an appointed associate will maintain meeting minutes and actions taken, with records of these meetings maintained throughout the entire Contract term. The Humana leader will be responsible for working with the appropriate functional area(s) to implement program and policy improvements according to the action plans. We will present the insights obtained and action plans implemented as a result of monthly meetings to the Department. At each meeting, we will review progress on ongoing action plans and discuss further improvements.

ALL-MCO MEETING FORMAT

Meeting Description and Objectives

Regular meetings with broad representation from the local Medicaid ecosystem enable unique collaborative solutions that can only be achieved through system-wide change. Many challenges are best addressed by sharing best practices between and among MCOs or by developing consistency and standardization among MCOs. For example, if MCOs work together to develop a consistent set of quality measures for value-based payment programs, we can improve health outcomes by simplifying the programs for providers. Inviting other agencies and stakeholders to participate will help us identify challenges and solutions. For example, as Humana continues expanding its efforts to address Enrollees' social determinants of health, we see significant opportunities to develop collaborative solutions with agencies responsible for issues such as housing and workforce development.

Meeting Format, Attendees, and Agenda

Humana recommends maintaining a quarterly cadence for All-MCO collaboration meetings. To reduce administrative burden on DMS, we propose that the Kentucky Association of Health Plans (KAHP) host the quarterly meetings. As the “All-MCO” name implies, the CEO from each MCO should be required to attend each meeting, along with any subject matter experts with experience relevant to the topics on the agenda. Likewise, we recommend that the Commissioner from DMS be present with relevant support personnel.

In recognition of the complex network of other Commonwealth departments that work with our Enrollees on the Medicaid continuum of care, we recommend inviting departments such as DCBS, the Kentucky Commission for Children with Special Health Care Needs, the Department for Public Health (DPH), and DBHDID to attend meetings on a quarterly basis. Additionally, we recommend inviting local city and county-based agencies and organizations – such as public health agencies – to participate as appropriate based on the agenda. To improve collaboration, we recommend an in-person attendance requirement for MCOs but allow teleconference attendance for other stakeholders.

The KAHP director will serve as the meeting facilitator with responsibility for setting the quarterly agenda. DMS should maintain optional authority to prescribe meeting topics. Otherwise, the KAHP director will set topics based on input from MCOs and other agencies and/or stakeholders. In the event that meeting attendees disagree on meeting topics, KAHP will hold a vote to determine which topics will be addressed, with other topics prioritized for the next quarterly meeting. Meeting agendas should be confirmed at least one week in advance to ensure productive and efficient collaboration among all parties.

Humana recommends the following agenda structure for each meeting:

- Approval of the minutes from the previous meeting
- Status review of outstanding and ongoing action items
- New issue review and associated action plans
- Assignment of new action items to responsible parties
- Adjournment

Tracking and Reporting

For each meeting, Humana’s, Mr. Duke, or appointed associate will maintain meeting minutes and actions taken, with records of these meetings maintained throughout the entire Contract term. We will use feedback received during the meeting to develop action plans to address each concern. Mr. Duke will be responsible for working with the appropriate functional area(s) to implement program and policy improvements according to the action plans. We will present the insights obtained and action plans implemented as a result of quarterly All-MCO Meetings to the Department. At each meeting, we will review progress on ongoing action plans and discuss further improvements.

a.ii.

Examples of issues, ideas, and innovations that the Vendor thinks should be addressed during the initial three (3) to six (6) meetings, the rationale for each, and whether collaboration for each will require implementation of short-term and/or long-term solutions.

While we have extensive experience implementing new Medicaid Managed Care (MMC) programs, with respect to this program, Humana is an incumbent with a longstanding Kentucky Medicaid health plan with proven associates, programs, and processes. As a result, our first meetings under the new Contract will be a collaborative process with DMS to identify the operations they seek to test. A team of Humana subject matter experts will participate on our Interim Operating Team with responsibility for providing DMS staff with easy access to our associates, systems, and information. This team will be led by Mr. Duke, who will ensure 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, 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.

During the initial three to six monthly meetings, we recommend a focus on the following issues and ideas related to new program requirements and implementation metrics that define a successful program launch:

- Compliance with new Contract requirements or request for proposal (RFP) commitments
- New Enrollee Onboarding
- Staffing
- Continuity of Care
- Credentialing Verification Organization (CVO)

COMPLIANCE WITH NEW CONTRACT REQUIREMENTS OR RFP COMMITMENTS

Rationale: To ensure new program requirements and MCO-specific RFP commitments are met, we recommend developing detailed project plans to track progress toward defined goals and objectives.

Implementation: These issues will require a combination of short-term solutions, such as establishing a task force to address programmatic changes, and long-term solutions, such as building new data feeds to support enhanced reporting.

NEW ENROLLEE ONBOARDING

Rationale: New managed care Contract procurements often result in an influx of new Enrollees to the awarded MCOs. Effective onboarding ensures Enrollees understand important program topics, such as Enrollee ID cards, Covered Services, and how to select a primary care provider (PCP).

Implementation: This will require short-term implementation of tracking enrollment metrics and feedback loops regarding Enrollee information materials, ID cards, grievances, PCP selection or assignment, and Health Risk Assessment completion, which would result in a better Enrollee experience.



STAFFING

Rationale: While Humana is currently staffed appropriately to effectively manage its health plan with more than 145,000 Enrollees, we understand the need to prepare for a substantial increase in Enrollees.

Implementation: Humana's Kentucky headquarters affords us a unique advantage to staffing and scalability. With more than 12,000 Humana associates currently based in the Commonwealth, **we have the internal candidates and local talent pipeline to rapidly hire and train the staff needed to manage a significant increase in membership.** As a result, this challenge will require implementation of short-term solutions.

Upon Contract award, each Humana associate will go through a thorough and rigorous training on the nuances and requirements of the new Draft Medicaid Contract. Each department, including Program Integrity, Claims and Encounters, Population Health, and others will receive specialized departmental training.

CONTINUITY OF CARE

Rationale: Ensuring the smooth transition of Enrollees from one MCO to the other is critical to prevent avoidable emergency department (ED) visits or hospitalizations. This is equally important whether Enrollees are transitioning to or away from Humana.

Implementation: To maintain continuity of care, we consistently and proactively send the transitioning Enrollee's information (including care plans and authorizations) to the other health plan every week. To minimize Enrollee and provider friction during times of transition between plans, it is critical that regular reviews of Enrollee authorization data, claims receipts, and claims denials provide evidence of Enrollee access to previous existing care.

CREDENTIALING VERIFICATION ORGANIZATION (CVO) IMPLEMENTATION

Rationale: Humana has strict, documented credentialing and re-credentialing policy and procedure processes in place, designed to reflect and capture the highest level of credentialing requirements amongst all governing agencies, including the requirements of the Kentucky Medicaid Contract, federal requirements, and National Committee for Quality Assurance guidelines. Humana will work collaboratively with the contracted CVO(s) and the Department upon selection of the CVO(s). Humana's Provider Network director will serve as a liaison to coordinate and oversee the relationship with the CVO(s) to ensure we address any concerns or issues that may arise during the implementation of streamlined credentialing. Further, Humana will review for opportunities to integrate commercial and Medicare credentialing within the process to achieve a streamlined process. We feel this multi-product integration will make a true impact toward lowered provider administrative burden.



Implementation: Transitioning credentialing activities to the newly-contracted CVO will require the short-term implementation of technology to exchange files with the CVO and updating Provider Manuals, orientation, and portals to reflect the change. It will also require long-term solutions in the form of continued training to help providers understand the transition.

BEYOND THE INITIAL MEETINGS: LONG-TERM STRATEGIC PLAN

Humana's approach to the MMC program seeks to drive improved Enrollee outcomes and quality through community and provider partnerships, systems integration, and Enrollee engagement. Humana intends to delineate the components of our strategy by aligning with DMS on specific Contract goals that will guide future progress updates and drive accountability for improving outcomes. This approach will ensure DMS has a clear view of Humana's Strategic Long-Term Plan, which should include implementing the following long-term solutions.

- **Potentially Preventable Event (PPE) Tracking:** Humana has a partnership with 3M to analyze, track, and report preventable ED visits, hospitalizations, and readmissions. The standardized third-party assessment through 3M offers an unbiased assessment to benchmark outcomes against industry standards. Humana reduced ED visits by 11.7% from 2017 to 2018, and this technology will give DMS the transparency needed to hold all MCOs accountable for continuous progress reducing PPEs. Humana will propose an approach to PPE technology integration, reporting components, strategy integration, and development of initial benchmarks and goals.
- **Value-Based Payment (VBP):** Humana currently has more than 131,000 Medicare Advantage Enrollees attributed to Kentucky providers in VBP arrangements, representing 81% of our enrollees as of mid-2019. [REDACTED] VBP improves our longstanding relationships with local providers but more importantly, we have seen significant reductions in ED visits and hospital admissions as a result. Humana will take a collaborative approach with DMS to review programs and share best practices as we implement new VBP programs for Kentucky Medicaid providers.
- **Duals Integration:** Humana has significant experience coordinating care for Enrollees who are dually eligible for Medicaid and Medicare, with more than 4.0 million Medicare Enrollees, including more than 675,000 dual-eligibles in our membership. We understand these Enrollees' unique characteristics, the challenges they face with fragmented coverage, and how to improve health outcomes through care coordination.
- **Telehealth Integration:** We will use the MDLIVE virtual care platform to offer our Kentucky Medicaid Enrollees telehealth capabilities aimed at reducing ED visits. Enrollees will have access to 1) Medical Virtual Visits through which they can access licensed healthcare professionals with prescribing authority for diagnosis and treatment of common non-emergency illnesses, 2) Mental and Behavioral Health Virtual Visits through teletherapy and telepsychiatry, where Enrollees can see a licensed therapist or board-certified psychiatrist face-to-face from the comfort of their home, and 3) Primary Care Virtual Visits to address follow-up care needs between visits with Enrollees' PCP and to access primary care for healthcare

needs. All MDLIVE providers offering telehealth services to our Kentucky Enrollees are required to be a licensed Kentucky Medicaid provider in good standing. The MDLIVE platform and related applications allow patients and providers to access a secure virtual care environment via web and native mobile applications. Additionally, MDLIVE's platform and applications can integrate with the leading electronic health record systems, including the Kentucky Health Information Exchange and patient portals. These integrated capabilities enable providers to support on-demand and scheduled virtual care as part of their workflow and enable patients to request and confirm telehealth visits.

- **Addressing Provider Shortages:** Upon Contract award, we will initiate a collaborative effort with the Department and across all selected MCOs dedicated to addressing workforce shortages in designated areas. Actions of the collaboration may include, but are not limited to, supporting initiatives that create opportunities for medical schools and para-medicine programs to partner with high schools in shortage areas. These partnerships may include designing and offering courses for high school students interested in careers in medicine. Participating students meeting the program's qualifications will be eligible for advanced degree scholarships contingent upon agreement to practice in a workforce shortage area upon graduation and receipt of required credentials for their specialty.
- **First Responder Home Health:** Additional collaborative opportunities may include developing and sponsoring certification programs for local emergency responders to deliver on-demand house call services for Enrollees with accessibility challenges. These programs can increase capacity and provider availability in workforce shortage areas. In partnership with area health systems and hospitals, an Emergency Medical Technician or other medical professional can be dispatched directly to an Enrollee's home for assessment and treatment. Using a tablet device, the first responder will have the ability to contact a participating physician or certified nurse practitioner once they arrive at the Enrollee's residence for a telehealth consult, including point-of-care testing and medication prescribing. Ultimately, this program reduces inappropriate use of the ED, increases access to care for Enrollees, and increases existing provider workforce capacity.



b.

Describe lessons learned from similar collaborations that the Vendor has experienced, and how those could be applied in moving forward with monthly meetings.

Humana has supported similar collaborations in other Medicaid programs. Through this experience we have learned many lessons that will directly apply to the Kentucky MMC program.

Lesson 1: System-wide changes are best addressed through collaboration across all MCOs

Coordination between and among organizations streamlines implementation of new regulations and technology such as Electronic Visit Verification (EVV). Implementation of new EVV regulations – under the 21st Century Cures Act – will help ensure care is provided as prescribed and reduce the risk of Fraud, Waste, and Abuse (FWA) amongst home health providers. However, the implementation of EVV poses a risk of significant disruption of provider billings practices, home health caregiver compensation, and consumer-directed responsibilities. Since November 2018, Humana has attended bi-weekly collaboration meetings with other Florida Medicaid MCOs to discuss approaches to technology, process, and communication strategies to address the requirements as detailed by regulation and Medicaid agency guidance.

During the meeting series, we have discussed the following topics:

- Technology solutions that best support the needs of MCOs, providers, and Enrollees
- Tools currently available regarding consumer direction and home health providers
- Data and reporting elements required to analyze the program
- EVV program integration with current FWA activities
- Provider training and communication on this new technology and regulation
- Limiting disruption to Enrollee experience

Through this process we were able to achieve several key objectives:

- Joint provider information sessions hosted across the state of Florida
- Aligned vendors and technology in order to simplify the provider experience
- Phasing of program with regional pilots and step up requirements
- MCO-funded support for preferred technology
- Clearinghouse integration
- Seamless integration of authorization delivery and EVV platforms

Humana has successfully implemented a compliant EVV solution to support our Florida Medicaid health plan. Through this joint effort among MCOs, home health providers can now use a single EVV platform to manage their visits with Enrollees across the three largest Medicaid MCOs at no cost to them. This alleviates the administrative and financial burden of this new regulation, giving providers the opportunity to focus on what is important: providing high-quality care to our Enrollees. Humana learned a valuable lesson through this process: To effectively implement system-wide changes, all Medicaid MCOs should collaborate to share best practices, develop standardized solutions, and help the Commonwealth define appropriate reporting requirements. **We will apply this lesson in Kentucky by proposing impactful initiatives in quarterly All-MCO Meetings and by collaboratively sharing best practices to improve health outcomes with other MCOs.**

Lesson 2: Collaborative flexibility from Medicaid agencies enables success

In 2015, Florida's Medicaid agency launched a program-wide VBP program designed to increase reimbursement rates for high-quality PCPs, OB/GYNs, and pediatric specialists. All Medicaid MCOs participate in the program, called the Medicaid Medical Assistance (MMA) Physician Incentive Program (MPIP). As a result, MPIP creates consistency in VBP programming across MCOs. This consistency helps providers who might otherwise need training across many MCOs' varying VBP programs. The State collaborated with Humana and other MCOs to develop a flexible approach to the MPIP program design, which has enabled its success.

Initially, the State developed a standard MPIP program for all MCOs to implement. Drawing upon decades of experience and national best practices, Humana offered to help the State refine underlying quality measures, such as reducing preventable ED visits and hospitalizations and improving birth outcomes, to ensure the VBP program meets its goals. The State was receptive and appreciative of Humana's approach, and subsequently gave MCOs flexibility to tailor MPIP quality measures, subject to their approval. Humana implemented new MPIP quality measures – such as ED visit rates and Healthcare Effectiveness Data and Information Set measures regarding prenatal care – that have improved health outcomes through other Humana VBP programs. **As a result of this collaborative approach, the MPIP program has improved performance and health outcomes, and it has increased payment rates for providers.** From 2016 to 2018:



- The number of PCPs that qualified for MPIP rewards doubled
- The number of qualifying OB/GYNs under MPIP more than tripled
- The total incentives paid to PCPs under MPIP increased 32%
- The total MPIP incentives paid to OB/GYNs increased 250%

We will apply the lesson learned from this collaboration to our Kentucky Medicaid health plan by identifying opportunities to reduce administrative burden for providers by collaboratively developing similarly standardized programs across MCOs.

Lesson 3: MCOs need to take initiative to independently collaborate

In our Virginia Medicaid-Medicare Financial Alignment Initiative health plan, we identified a challenge regarding nursing facility (NF) providers' understanding of appropriate coding procedures, which was creating frustration regarding claims denials. The providers needed education to identify the different codes and modifiers associated with different types of services and also needed the claims submission process to be streamlined to make it easier. All participating MCOs created a subgroup amongst themselves to develop a standardized claims submission format and process, with the required elements needed for all MCOs' claims processes. Humana led

this collaborative effort by sharing an educational claims submission tool that our team had developed for providers. After sharing this tool with other MCOs, there was program-wide adoption, and claims denials for NF providers quickly fell as a result.

To apply the lesson learned from this collaboration in the Kentucky Medicaid plan, we will proactively identify system-wide issues and use the Quarterly All-MCO meeting to collectively develop solutions and track progress on their implementation.

Lesson 4: Recurring agenda topics in one-on-one MCO meetings are needed to solve complex challenges

Humana has a proven track record of success in being a collaborative partner to ensure Enrollees' needs are properly addressed. We take great pride in communication and collaboration to build effective and efficient solutions. One example of this collaboration can be highlighted through the partnership with the Florida Agency for Health Care Administration (AHCA) on Medicare and Medicaid crossover claims. As a result of this partnership, Humana was the first MCO within the state to implement an automated adjudication process for services covered under both Medicare and Medicaid. Through one-on-one meetings with the Agency and Humana, we found that provider abrasion existed for services covered under both Medicare and Medicaid. As a result of our trusted relationship with the Agency and our demonstrated knowledge of claims processing, Humana was uniquely positioned to answer the needs of the provider community and state agency.

To achieve success in reducing provider abrasion and administrative tasks, Humana brought its claims subject matter experts to help both AHCA and CMS navigate the intricacies of different platforms. Through open communication, structured meetings, and detailed testing, we were able to reduce provider abrasion by systematically routing post-Medicare adjudication claims to Humana's Medicaid claims platform for automated adjudication under Medicaid. This solution reduces providers' administrative burden, as they now only need to submit one claim for a single service even if reimbursement is coming from two payers. Not only does this reduce administrative responsibilities of the provider, but it also reduces the time lag for payment of service. As a result, Humana now processes more than 12,000 crossover claims monthly.

This example highlights an important lesson learned about collaborative long-term planning to address complex challenges. To best implement the process and technology solutions needed to solve this problem, we developed a strategic plan and provided regular reporting to the State to report progress, barriers, and next steps. The State's willingness to keep this issue on the agenda in a structured but collaborative meeting format enabled the ultimate success of the initiative. **We will apply the lesson learned from this collaboration to our Kentucky Medicaid plan by working with DMS to develop a standing agenda that encompasses all aspects relevant to program operations and strategic planning.**