









**C. Technical Approach**

**3. Capitation Payments (Section 10.0 Capitation Payment Information, Section 11.0 Rate Component)**

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

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

We regularly analyze the performance of our VBP programs to identify best practices and opportunities for improvement. Recent analysis shows that Humana’s VBP programs are improving quality and lowering costs. The results below illustrate the performance improvement of providers in Humana’s Medicare Advantage (MA) value-based arrangements across a variety of Healthcare Effectiveness Data and Information Set (HEDIS) measures, as compared to providers in our MA fee-for-service (FFS) arrangements.

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

**a. Describe proposed approaches for Physician Incentive Plans, including innovative approaches to incent provider behavior and participation.**

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

we offer larger financial incentives to providers at each level along the path toward full value. Humana plans to offer VBP models for the following provider types:

- PCPs
- Behavioral Health (BH) Providers
- OB/GYNs
- Specialists

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

Table I.C.3-1 provides an overview of our intended incentive plans for Kentucky Medicaid.

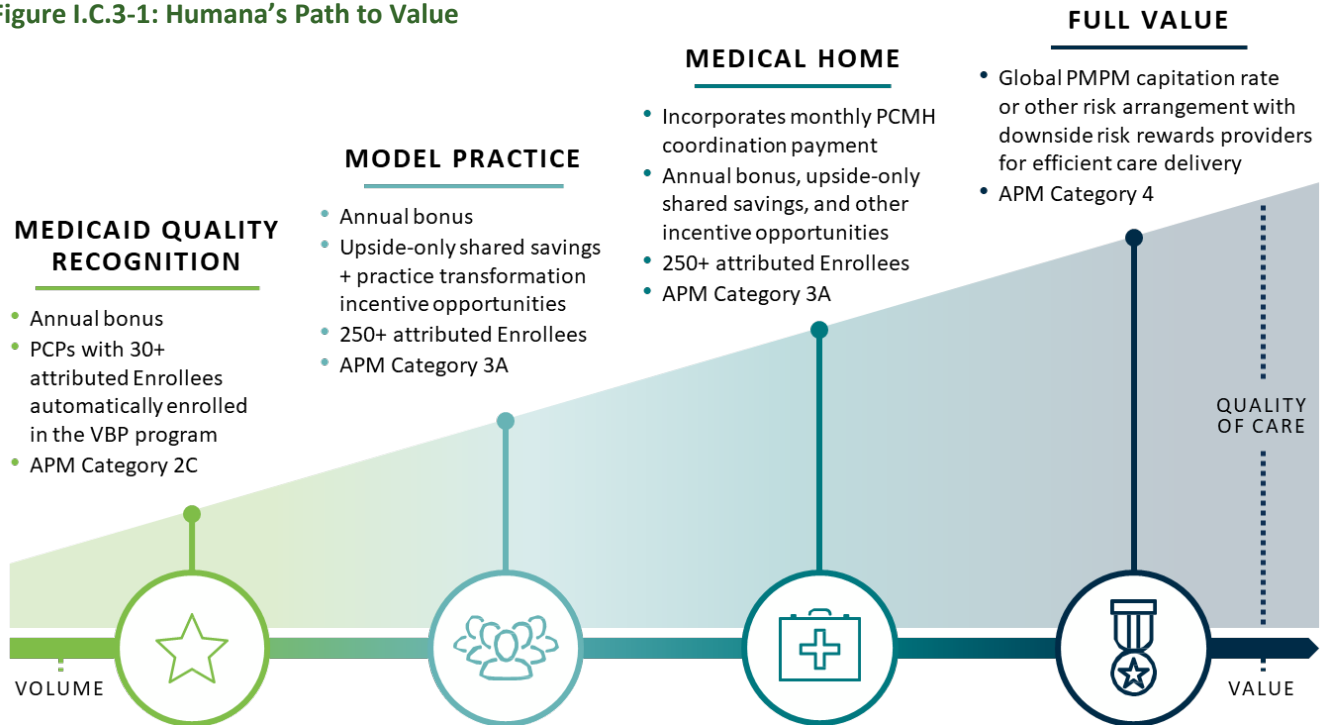
**Table I.C.3-1 Growing Value-Based Purchasing for Kentucky Medicaid**

Provider Type	APM Level	Detail
Primary Care Providers (PCPs)	2. Rewards Only	<u>Medicaid Quality Recognition</u> : Bonus for meeting quality and outcomes metrics
	3. Shared Savings	<u>Model Practice</u> : Bonus payment for meeting quality and outcomes metrics *Potential for upside-only shared savings *Practice Transformation Incentive (PTI)
		<u>Medical Home</u> : Bonus payment for meeting quality and outcomes metrics *Potential for upside-only shared savings *Practice Transformation Incentive *Monthly care coordination payment [for practices with Patient-Centered Medical Homes (PCMH) recognition]
	4. Full Risk	Monthly capitation payment [Per Member Per Month (PMPM)] or other risk arrangement that includes downside risk – providers have full responsibility for quality, outcomes, and cost
OB/GYN	2. Rewards Only	<u>Maternity VBP</u> : A rewards-only bonus payment program for OB/GYNs for meeting quality and outcomes metrics *Bonus payment for meeting quality outcomes and metrics Notice of Pregnancy Incentive Program
		3. Shared Savings
	4. Full Risk	N/A
Behavioral Health (BH)	2. Rewards Only	Behavioral Health Integration Referral Incentive
		Rapid Access Bonus
		Behavioral Health Medical Home Incentive
	3. Shared Savings	<u>Bundled Payment</u> : Case rate for Medication Assisted Treatment
4. Full Risk	N/A	
Other Specialist	2. Rewards Only	N/A
	3. Shared Savings	<u>Bundled Payments</u> : Total Joint Replacement, Spine Surgery
	4. Full Risk	N/A
<b>Additional Incentives Program</b>		
Extended Hours Bonus	[REDACTED]	

**VALUE-BASED PROGRAMS FOR PRIMARY CARE PROVIDERS**

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

**Figure I.C.3-1: Humana’s Path to Value**



**Medicaid Quality Recognition (MQR)**

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

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

**Model Practice**

The second step on the Path to Value is our Model Practice program. Model Practices assume greater accountability for managing patient care and therefore have the opportunity for greater rewards. The greater financial opportunity incentivizes providers to adjust their behavior and interventions, as necessary. PCPs meeting quality and outcomes goals across a set of predetermined metrics are eligible to receive an annual bonus payment as well as upside-only shared savings. In this program, practices are also eligible to receive a **Practice Transformation Incentive (PTI)**, a payment for mutually agreed-upon practice infrastructure

improvement investments, such as developing telehealth capabilities. A Humana Practice Innovation Advisor, a specialist on our Provider Relations Team, is available to advise providers on effective ways to invest the PTI into their practices. Practices become eligible to participate in the Model Practice program when they reach a minimum panel size of 250 attributed Enrollees. Providers are invited to participate in Model Practice following a formal assessment of the practice and its capacity to be successful in a shared savings model.

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

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

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



#### Expanding VBP to Medicaid – Provider Partnerships

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

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

#### Medical Home

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

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

#### Full Value

The final step on Humana's Path to Value is the Full Value program. In this model, Humana engages with providers in arrangements where providers fully coordinate and manage the cost of care. This may include a global capitation payment or other arrangements with downside risk. Before entering into a Full Value contract, Humana conducts a thorough assessment of the practice and its capacity to be successful. We assess practices across more than 30 parameters organized into five categories: infrastructure, engagement with Humana, potential for growth, clinical operations, and financial operations. Practices in Full Value have demonstrated

success meeting quality metrics with the staffing, processes, and capabilities needed to manage all aspects of patient care. For example, Full Value practices employ social workers or care management associates and referral teams to engage Enrollees identified as Unable to Contact. These practices also use EHRs, are connected to the Kentucky Health Information Exchange (KHIE), and have a HEDIS team that manages care gaps and develops action plans to resolve those gaps.

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

**Humana is raising the bar: Advancing VBP programs**

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

**VALUE-BASED PROGRAMS FOR BEHAVIORAL HEALTH PROVIDERS**

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

**Rapid Access Program**

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

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

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



### Collaboration with Community Mental Health Centers (CMHC)

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

We will also explore the opportunity to provide a **bundled payment to CMHCs to support the provision of high fidelity wraparound services**. Via our communication with BH providers, we learned funding presents a hurdle to the provision of this important, evidence-based service to Medicaid Enrollees. We intend for this bundled payment to lessen this burden and promote delivery of wraparound supports to our child and adolescent Enrollees with BH needs. These wraparound services will be critical to the Commonwealth's adoption of the Family First Prevention Services Act, which will support families and promote permanency.

### Behavioral Health Integration Referral Incentive

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

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

### Behavioral Health Medical Home Incentive

Humana is implementing an innovative new model that supports BH practices in becoming medical homes, which promotes the integration of physical and behavioral health. Increasing ease of access to physical health services for Enrollees with BH diagnoses leads to overall improved health and well-being. Through our network management initiatives, Humana will engage with selected BH practices to determine their interest and evaluate their capabilities to incorporate the offering of primary care services in their offices or clinics (e.g., hiring a primary care nurse practitioner). To identify potential BH practices for this program, Humana will review our network access and adequacy reports to first determine if there are BH providers in primary care shortage areas that may be eligible for the program. Following agreement between Humana and the BH practice, Humana will remit the BH Medical Home Incentive for the addition of primary care services.

### Bundled Payments for Medication Assisted Treatment (MAT)

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

### **MATERNITY-FOCUSED VBP PROGRAMS TO IMPROVE BIRTH OUTCOMES**

The infant mortality rate is 21% higher in Appalachian Kentucky than the national average and 10% higher than in non-Appalachian Kentucky.<sup>1</sup> Clinical strategies focused on prenatal care have been successful in reducing infant mortality. Incentivizing OB/GYN providers to improve performance on related quality measures will complement providers' clinical strategies and improve birth outcomes in Kentucky.

#### **Maternity Incentive Program**

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

#### **Notice of Pregnancy Incentive Program**

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

### **VALUE-BASED PROGRAMS FOR SPECIALISTS**

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

### **EXTENDED HOURS BONUS FOR PCPS AND BH PROVIDERS**

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

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

b.

Provide examples of successful Physician Incentive Plans the Vendor has implemented, including information about their structure, measurable outcomes, challenges and lessons learned.

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

### **EXAMPLES OF SUCCESSFUL PHYSICIAN INCENTIVE PLANS**

#### **Florida Quality Bonus Program**

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

[REDACTED] The bonuses offered through this program incentivize providers to implement interventions that improve HEDIS measures related to reducing preventable events. As providers assume no risk

<sup>1</sup> Appalachian Regional Commission, Fact Sheets: Health Disparities in Appalachia. August 2017.

[https://www.arc.gov/images/appregion/fact\\_sheets/HealthDisparities2017/KYHealthDisparitiesKeyFindings8-17.pdf](https://www.arc.gov/images/appregion/fact_sheets/HealthDisparities2017/KYHealthDisparitiesKeyFindings8-17.pdf)

in this model, it serves as an introduction to VBP and prepares providers to move along the continuum toward more advanced arrangements.

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

- 9.24% increase in adults receiving body mass index (BMI) assessments
- 3.95% increase in breast cancer screenings
- 3.39% increase in cervical cancer screenings
- 2.48% increase in adolescent well-care visits

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

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

### Pediatric Associates

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

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

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

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



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

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

Additionally, our experience with Pediatric Associates demonstrates the importance of sharing data and communicating clearly with providers as a means of increasing provider engagement and interest in the program. Maintaining meaningful contact with providers can be challenging, which is why we invested in a robust provider services organization in our Florida market. These Provider Relations representatives specialize in facilitating clear, useful communications and in effective data sharing, which enhances provider participation and generates actionable goals, leading to improved quality results. These lessons certainly apply in the Commonwealth of Kentucky and will greatly influence our efforts to build meaningful relationships with providers in the Kentucky communities we serve.

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

### Norton Healthcare

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

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

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

Our longstanding relationship with Norton has developed over many years and evolved into a full value risk arrangement with Norton approximately three years ago. The success of this arrangement reflects Norton's dedication to quality improvement, and it also reflects the lessons Humana has learned regarding the need to offer a continuum of VBP programs and our support of providers' progression toward this type of advanced arrangement. This is why our Path to Value VBP continuum offers various levels of risk and reward, ranging from

zero risk, rewards-only programs to global risk opportunities. Our goal is to meet providers where they are with an appropriate VBP model for their current capabilities and then help them develop the infrastructure and resources necessary to be successful in more advanced risk arrangements.

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

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