

C. Technical Approach

4. Financial Security Obligations (Section 13.0 Contractor's Financial Security Obligations)

a. Describe how the Vendor will comply with net worth, solvency, and surplus requirements.

Humana has a quarterly capital management process whereby all of its appropriately 35 legal entities are reviewed to ensure NAIC risk-based capital (RBC), state, and contract requirements are maintained. Target net worth levels are also established above these requirements to ensure an excess level of net worth is maintained above the actual requirements. Prior to quarter end reporting, premium and profitability are reviewed to ensure we understand growth and other underwriting risk changes. During the quarterly close we calculate each state specific and contract requirement for all states that a legal entity is licensed to ensure all requirements are being met. Annually, the NAIC RBC is calculated, and we perform high level analysis for year-over-year changes in all risk categories. There is close coordination among financial reporting, treasury, and legal teams to plan for potential capital contributions or dividends, if applicable. Specifically on December 31, 2018, Humana Health Plan, Inc. reported \$757.9 million in total adjusted capital with an RBC ratio of 661.6%, or over three times the amount required per NAIC and Kentucky regulations. Humana Health Plan, Inc. historically has, currently has, and in the future will maintain strong capitalization ratios. Please refer to **Attachment I.C.4-1** for a copy of the most recent Risk Based Capital calculation for Humana Health Plan, Inc.

b. Provide documentation of lines of credit that are available, including maximum credit amounts and available credit amount.

Humana Health Plan, Inc. does not maintain independent lines of credit. However, Humana Health Plan, Inc. has an indemnity agreement with its parent organization, Humana Inc., whereby Humana Inc. will continue coverage for Enrollees for the duration of the Contract period for which payment has been made and will continue benefits for Enrollees and policyholders.

Humana Inc., Humana Health Plan, Inc.'s direct and ultimate parent company, is a \$65 billion Fortune 100 company with excess reserves, untapped credit lines, and an investment grade bond issuer with significant capacity to expand that will provide working capital in the event of an unforeseen cash shortfall.

Humana Inc.'s five-year, \$2 billion unsecured revolving credit agreement expires May 2022. Under the credit agreement, at its option, Humana can borrow on either a competitive advance basis or a revolving credit basis. As of December 31, 2018, we had no borrowings and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2018, we had \$2 billion of remaining borrowing capacity (which excludes the uncommitted \$500 million incremental loan facility under the credit agreement) – none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Humana Inc. has always and will continue to fully support its subsidiaries financially, operationally, and strategically.

For additional information regarding Humana Inc.'s credit agreement, please refer to the Credit Agreement section within Humana Inc.'s 2018 10-K report (**Attachment I.B.2-12**; page 114).

c.

Describe any risk arrangements the Vendor proposes to have with providers for contracted services and describe oversight of such arrangements.

PROPOSED PROVIDER RISK ARRANGEMENTS

Humana offers a variety of value-based payment (VBP) programs across the full spectrum of the Healthcare Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) framework. We work closely with our provider partners to determine the most appropriate VBP model based on patient panel, practice size and type, personnel and technological capabilities, and previous experience with VBP arrangements.

We describe VBP programs involving providers in risk arrangements below (for a full discussion of Humana’s VBP programs, please refer to our response to I.C.3 Capitation Payments).

- **Full Value Program [Primary Care Providers (PCPs)]:** Under our Full Value program for PCPs, 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. Practices in Full Value have demonstrated success meeting quality metrics with the staffing, processes, and capabilities needed to manage all aspects of patient care. These practices use electronic health records, are connected to the Kentucky Health Information Exchange, and have a Health Effectiveness Data and Information Set (HEDIS) team that manages care gaps and develops action plans to resolve those gaps. Humana will risk-adjust provider payment rates to reflect the risk of the attributed population.
- **Bundled Payments (Specialists):** Humana will implement bundled payment programs covering a full range of services across several types of episodes of care, including Medication Assisted Treatment for opioid addiction, maternity care, total joint replacement, and spine surgery.

APPROACH TO OVERSIGHT OF PROVIDER RISK ARRANGEMENTS

Rather than pushing a top-down or one-size-fits-all methodology, Humana’s approach to oversight of provider risk arrangements emphasizes the development of strong partnerships to drive improved health outcomes and deliver cost-effective care. Our highly collaborative approach allows providers to retain leadership over clinical decision-making and patient management while leveraging Humana’s expertise in Population Health Management and extensive data analytic capabilities.

Together, the transparency and open dialogue cultivated within the partnership ensures early identification of financial issues to prevent jeopardizing the provider’s business viability or participation in the Humana network. We outline the key principles of Humana’s approach to oversight of risk-based providers below.

Dedicated Support: Humana assigns a Provider Relations (PR) representative for each provider in a risk-based arrangement, offering a single point of contact to quickly resolve questions, distribute information, and monitor the status of key issues and initiatives. The PR representative serves as a “one-stop shop” to our provider partners and acts as an advocate for the provider group in escalating needs and sharing best practices derived from Humana’s extensive experience in value-based care models.

Due Diligence: Humana works with providers to determine the VBP arrangement that suits their current capabilities, experience, and readiness. For example, before entering into a Full Value Contract with a PCP group, Humana conducts a thorough assessment of the practice across more than 30 parameters organized into five categories: infrastructure, engagement with Humana, potential for growth, clinical operations, and financial operations.

Ongoing Monitoring and Performance Review: To protect Full Value providers from excessive downside risk, Humana follows the Centers for Medicare and Medicaid Services stop-loss protections as defined in 42 CFR § 422.208, which require aggregate stop-loss protection to cover 90% of the costs of referral services that exceed 25% of potential payments. Humana also maintains flexibility to accommodate the needs of our provider partners after entering into risk-based arrangements. If a provider group or a particular clinical site is struggling

with meeting cost goals, we provide consultative guidance while removing the risk element for a period of time (e.g., six months), after which we review performance to determine whether it is appropriate to re-enter the risk arrangement. Additionally, while our quality measures and program design reflect Commonwealth Medicaid agency policy goals, as well as performance measures found to directly drive improved outcomes, Humana constantly refines our VBP program methodology and works with our provider partners to identify areas of focus.

Humana has delegated claims processing functionality to some of our more advanced risk-based providers paid under capitation agreements. While we are not proposing such arrangements as part of our Kentucky Medicaid Managed Care program network at this time, we have developed sophisticated oversight mechanisms to ensure the financial security of these delegated providers. Our Solvency Task Force, composed of Humana subject matter experts from across our organization, including Risk Management, Internal Audit, Product Team (e.g., Medicare or Medicaid), Network Operations, Delegation Compliance, Finance, and Market Operations, has developed a financial solvency risk scoring methodology that includes a detailed analysis of the provider's financial statements, as well as Humana membership and capitation volume. We use this analysis to produce Claims Delegation Risk reports, which are updated following the solvency reviews and audit results of the claim delegates that take place during annual Claims Delegation Oversight audits. The Solvency Task Force meets quarterly to review the updated Claims Delegation Risk reports. We discuss in detail all claim delegates receiving a high or moderate risk score on the Risk reports during these quarterly meetings, and Humana contacts these providers to address concerns and take corrective action where warranted. Should Humana enter into a claims delegation and capitation arrangement with a Kentucky Medicaid provider, the Solvency Task Force would provide this highly detailed level of oversight of the arrangement.



Strategic Partnership: Humana convenes a Joint Operating Committee (JOC) meeting with its provider partners at least annually. The JOC's purpose is to set clinical and operational strategy and identify opportunities for leveraging competencies from across the Humana organization, including finance, health services, pharmacy, and network services.



As our operational relationships with providers mature, we have found that the JOC meetings naturally begin to focus more on clinical issues and explore opportunities to develop and strengthen relationships with community organizations to address health-related social needs. With many providers, we have started to conduct frequent JOC meetings to focus on specific clinical issues, such as behavioral health integration.

Frequent Communication: In addition to offering a dedicated point of contact through the PR representative, Humana holds regular leadership meetings with our VBP providers to discuss clinical and operational issues, new initiatives, and strategies for performance improvement. Examples of issues discussed at these meetings include:

- Quality of Care
 - Conducting Enrollee outreach to close gaps in care
 - Ensuring on-time access to care
- Hospital and Emergency Department (ED) Utilization
 - Reviewing the "frequent flyers" list and collaborating to refer Enrollees to Humana care management programs where appropriate
 - Educating Enrollees on after-hours and weekend availability
 - Ensuring urgent appointments are available during office hours
 - Evaluating usage of urgent care facilities for non-emergent cases
 - Establishing delivery system aligned with most cost-effective hospitals
- Referral Management
 - Helping provider leadership identify referral patterns

- Managing referral requests to ensure patients see specialists within the capitated network or the otherwise most cost-effective providers, where appropriate
- Pharmacy Utilization
 - Increasing generic dispensing rate
 - Complying with the state preferred drug list

These meetings also serve as an opportunity to communicate important Commonwealth policy changes (e.g., State legislation limiting CII opioid supply size).

Actionable Data: Humana also provides frequent cost and quality reporting, which includes actionable patient-level data at the organizational, clinical site, and provider level. Examples of such reporting include, but are not limited to:

- Gaps in Care for HEDIS quality measures and current quality ratings
- “Frequent Flyer” reports detailing the most frequent and expensive utilizers of ED and ambulance services
- Most expensive Enrollees by clinical site and overall provider group
- Total year-to-date claims data
- Hospital inpatient spending, including top diagnoses, top hospitals, and most expensive Enrollees
- Outpatient spending, including top diagnoses, top sites, and most expensive Enrollees
- Pharmacy trends and opportunities for generic substitution