C.	**Technical Approach**

9.	**Quality Management and Health Outcomes** (Section 19.0 Quality Management and Health Outcomes)

a.	Provide a detailed description of how the Vendor will support the Department in achieving its goals to transform the Medicaid program to empower individuals to improve their health and engage in their healthcare and to significantly improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities. At a minimum, the Vendor's response should address:

At Humana, quality improvement (QI) is a core value that guides our day-to-day behaviors, decisions, and actions. Our performance in National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) ratings demonstrates a comprehensive, organization-wide commitment to quality and continuous quality improvement (CQI).

- Humana currently operates an **NCQA-accredited Medicaid plan in Kentucky**. We have four additional NCQA-accredited plans (in other lines of business) in Kentucky, two of which have a Commendable status.
- Our NCQA-accredited **Florida Medicaid plan is tied for first in quality** among 12 participating Florida Medicaid plans, according to NCQA.[1]
- Humana operates **37 NCQA-accredited health plans** nationwide across our Commercial, Medicaid, and Medicare Advantage (MA) lines of business; **20 plans have a Commendable status**.
- Humana leads all national MA plans with **92% of Humana MA Enrollees enrolled in 4.0-Star plans or higher** in 2019. Nationally, approximately 244,000 Humana Medicare Enrollees are in 5-Star rated (a perfect rating) health plans.
- Humana employs **more than 1,000 associates fully dedicated to QI throughout our organization**.

HUMANA'S QUALITY STRATEGY

We have developed our Medicaid quality strategy through more than 20 years of serving Medicaid Enrollees, and we will apply this strategy in Kentucky to empower and engage individuals to improve their health, to significantly improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities in the Commonwealth. Our quality strategy, spearheaded by our Quality Improvement Director, Audra Summers, RN, PMHNP, includes:

> **Humana's Quality Commitment in Kentucky**
>
> We will achieve an NCQA Commendable accreditation at our next survey under the executed Contract and an NCQA 3.5-Star plan rating by year three of the executed Contract for our Kentucky Medicaid health plan.

- Ensure timely access to proactive medical, behavioral health (BH), and pharmacy services
- Facilitate innovative, person-centered, whole person, coordinated care
- Promote wellness and prevention
- Improve Enrollee self-management of chronic physical and BH conditions
- Connect with physicians and community resources to address Social Determinants of Health (SDOH)
- Work in partnership with local businesses, non-profits, educators, and government organizations to improve the health of the communities we serve
- Support our providers with actionable data and feedback

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[1] http:// http://healthinsuranceratings.ncqa.org/2019/search/Medicaid/FL

• Reward value and quality through innovative provider partnerships

We are excited and prepared to leverage our experience serving Medicaid Enrollees and the insight gleaned through our partnership with CareSource to bring our Kentucky Enrollees into Humana's fully integrated model as we help the Commonwealth transform its Medicaid program.

a.i.	How it will structure its organization to provide for a comprehensive and holistic approach to meet these goals, including coordination with Subcontractors and providers.

QI is engrained in Humana's culture, and our multidisciplinary program **integrates business units** to focus on the triple aim of providing high quality care, improving outcomes, and engaging in smart value-based spending. We integrate QI into the following key strategies to ensure we meet our QI goals.

Humana's **person-centered clinical delivery model** is based on the concept of "right care, right place, right time" and is focused on interventions and strategies to improve access to high-quality, high-value care. Our QI program structure supports and advances our **population health strategy** by providing a standardized means of measuring and monitoring performance and accountability of our prevention, care management, care delivery, and community health offerings. Data drive our population health programming, while measurement allows us to direct our programming in a way that best serves our membership.

> " **Focusing on quality means taking an enterprise-wide view of whatever we do, going beyond our own areas of expertise to understand the effect of our decision-making on our organization and those we serve.** "
>
> – Bruce Broussard, Humana President & Chief Executive Officer (CEO)

Humana is also deeply committed to improving outcomes and reducing unnecessary costs through provider engagement and **value-based payment (VBP) arrangements**. We have observed that these providers deliver better performance when offered thoughtful incentives (with significant emphasis on preventive care), consultative provider guidance, and care gap alerts that are integrated with comparative quality metrics and benchmarks.

We utilize **robust data analytics capabilities** to monitor quality performance across a wide array of indicators, and we monitor claims, encounter, and utilization data to track and identify gaps in care and develop interventions that not only help Enrollees access care and close care gaps but also help influence behavior changes that lead to healthier habits and more self-management of chronic conditions. We also use data analytics to build **multidimensional provider performance profiles** that reward high-value, efficient care and help providers improve health outcomes and the Enrollee experience.

QUALITY PROGRAM GOVERNING STRUCTURE, LEADERSHIP, AND COMMITTEE SUPPORT

Humana's quality organizational structure comprises our established **local Kentucky-based quality resources that are supported by our enterprise-wide resources**, bringing together best practices, infrastructure, and feedback from multiple sources (e.g., providers, Enrollees, associates, Subcontractors) that foster the delivery of high-quality care that improves health outcomes and empowers our Enrollees. We base our QI structure upon our more than 40 years of quality experience gained from multiple lines of business, industry best practices, and organizational values, as well as Commonwealth and federal regulations, Department for Medicaid Services (DMS) Contract requirements, accreditation standards, and national healthcare agency guidelines.

Oversight of Humana's QI Program

While the Humana Board of Directors is ultimately accountable for our Quality Management/Quality Improvement (QM/QI) program, the oversight of our quality program operations is driven and led by our Kentucky-based Quality Improvement Director, Audra Summers, RN, PMHNP, with support from our Kentucky
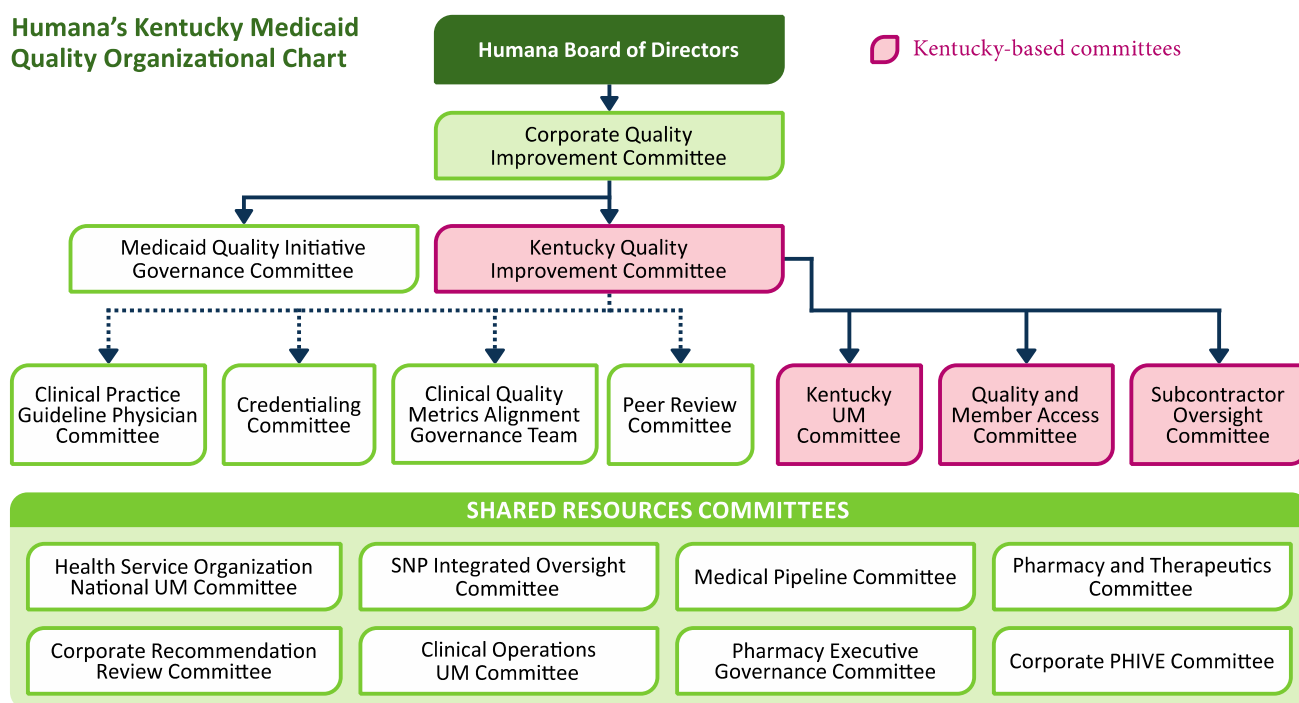
Medicaid Medical Director, Lisa Galloway, MD; BH Director, Liz Stearman, CSW, MSSW; and our Quality Assessment and Performance Improvement (QAPI) Coordinator, Brenda Stamper, RN; local QI associates; and local and national committees. We will detail and document the specific roles, responsibilities, and functions of our committees (included below) in our Humana Kentucky Medicaid QAPI Program Plan.

- Kentucky Quality Improvement Committee (QIC)
- Kentucky Utilization Management (UM) Committee
- Kentucky Quality and Member Access Committee (QMAC)
- Pharmacy and Therapeutics Committee
- Peer Review Committee
- Medicaid Quality Initiative Governance Committee
- Corporate Quality Improvement Committee (CQIC)
- Clinical Practice Guidelines (CPG) Physician Committee

Humana's QI program in Kentucky uses local quality resources supported by our national quality program. Our organizational chart, depicted in Figure I.C.9-1 below, illustrates Humana's departments and committees involved in ensuring a holistic and comprehensive approach to quality.

Figure I.C.9-1: Humana Quality Organizational Chart

Our Kentucky-based QIC is the hub of cross-departmental quality collaboration. All teams across the organization report into the QIC and participate in bi-directional feedback to drive direction towards our quality goals laid out in our Quality Improvement Work Plan (QIWP).

Local Quality Resources

With our corporate headquarters located in Louisville, Kentucky, Humana has a vested interest in the health and well-being of Kentuckians. We employ more than 12,000 associates across the Commonwealth, and we have **more than 100 Kentucky-based Humana associates specifically dedicated to supporting QI for our Kentucky Medicaid program**. These associates provide local oversight, regularly review quality metrics and data, and employ rapid-cycle improvement methods to continually monitor, assess, and assure the delivery of high-quality care. They work in tandem to implement a holistic quality strategy that prioritizes health disparities, care coordination, Enrollee satisfaction, and access to care in order to drive QI. Our associates responsible for administering and operating our Kentucky QM/QI program include:

ASSOCIATE SPOTLIGHT:
Audra Summers, RN, PMHNP

Audra is proud to be the Kentucky Medicaid QI Director. She has been a registered nurse for more than 25 years and earned a Masters in Nursing Science with a focus on adult psychiatry/mental health in 2005. During her more than 20 years with Humana, she has held many positions, including HEDIS Consultant and Senior Quality Improvement Professional in Corporate Quality Operations Compliance and Accreditation (QOCA). Audra's team is responsible for implementing Kentucky Medicaid's QAPI Program. Audra believes that utilizing data with strong processes and creative interventions with community partners will improve quality.

- Kentucky Medicaid Plan CEO: Our Plan CEO, Jeb Duke, has ultimate oversight of our Kentucky QM/QI program.
- Medicaid Medical Director: Our Medical Director, Lisa Galloway, MD, co-chairs the Kentucky QIC, reviews quality of care issues, and participates in case rounds when necessary.
- BH Director: Our BH Director, Liz Stearman, CSW, MMSW, is also directly involved in the operations of the quality program.
- Quality Improvement Director: Our QI Director, Audra Summers, RN, PMHNP, co-chairs the QIC and oversees the day-to-day operations of Humana's QI program in Kentucky. She plans, organizes, and directs the identification, prioritization, and implementation of strategic, data-driven projects and goals to achieve optimal performance and quality for our Kentucky Medicaid Plan. She works closely with the QAPI coordinator and those targeting specialized BH services to promote a company-wide culture of quality improvement.
- QAPI Coordinator: Humana's QAPI Coordinator, Brenda Stamper, RN, integrates quality throughout the organization by overseeing all areas related to clinical quality performance measures and improvement projects, as well as the development of intervention strategies, to ensure individual and systematic quality of care. She works closely with the QI Director and those targeting BH services.
- BH Quality Coordinator: Our BH Quality Coordinator is responsible for supporting the integration of physical health and BH while driving a BH focus into our QM/QI activities.
- Maternal Child Health/EPSDT Coordinator: Our Kentucky QM/QI program will include a Maternal Child Health/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coordinator, Martha Campbell. She is responsible for advancing quality outcomes for the respective segments of our Enrollee population.
- Quality Improvement Advisors (QIA): Our provider-facing QIAs work with our providers to educate on high utilization trends and Healthcare Effectiveness Data and Information Set (HEDIS)/Quality Performance trends, Enrollee experience best practices, and CPGs. Our QIAs are responsible for driving value-based care initiatives at our physician practices. They will share population health performance reporting and integrate Humana clinical programs and resources into practice workflows with the intent to optimize patient care, improve the provider experience, and enhance quality of care.

COORDINATION WITH ENROLLEES, PROVIDERS, AND SUBCONTRACTORS

Coordination with Enrollees

Humana empowers our Enrollees to have a meaningful impact on our QI program and structure through our local **QMAC**, which is led by Bryan Kennedy, our Culture & Community Engagement Director, and co-chaired by one of our Enrollees. As a local committee in our Kentucky quality structure, our QMAC serves as a forum for our Enrollees and/or their caregivers to provide feedback on their Humana experiences. The QMAC reviews and comments on various quality and access activities, educational activities, and materials related to accessibility of care and services. It also ensures that Humana takes the interests of Enrollees into account; therefore, in addition to Humana personnel, the committee membership includes individuals representing community advocacy groups and our Kentucky Medicaid Enrollees and caregivers. We use Enrollee information and feedback to identify areas of accomplishment and areas for improvement and utilize it in our **Enterprise Feedback Loop**. Our Enterprise Feedback Loop is a process and supporting technology that enables Humana to centrally collect, analyze, and prioritize Enrollee/provider feedback in order to eliminate friction points and improve the overall Enrollee experience. The goal of the Enterprise Feedback Loop is to proactively identify improvement opportunities we learn about them from our customers (e.g., Enrollees, providers). The purpose of the Enterprise Feedback Loop is to complete the following activities:

* Understand inputs such as surveys, grievances, performance metrics, internal audits, and others
* Develop insights by analyzing the information from the inputs
* Formulate an action plan to address the feedback

The QMAC's findings are overseen and discussed at the QIC where improvement actions based on those findings are developed and monitored.

Coordination with Providers

We coordinate with our providers regularly to ensure consistent delivery of high-quality care. Our Kentucky QIC fosters discussions amongst practicing physicians, advanced practice nurses (APN), and Humana clinical associates to discuss policy, programs, and quality initiatives. The QIC is responsible for oversight of the Kentucky Medicaid QAPI Program and includes network providers representing various specialties. Provider representatives on the QIC provide the perspective of the practicing physician, which facilitates development of clinical policy changes and new program implementation and keeps clinical operations relevant and grounded in evidence-based practices. Provider input, solicited from our Kentucky QIC, helps inform our QI priorities and identify areas where providers need additional support to improve the health of our Enrollees, including priority populations. We also use our QIAs to coordinate with our providers in QI activities. Using our proprietary **Population Insights Compass (Compass) suite**, the QIAs meet with providers face-to-face as a part of our provider engagement model to educate providers on performance metrics and QI initiatives. QIAs also work with our providers on how to increase Enrollee engagement in their own healthcare, leading to improved health outcomes.

Coordination with Subcontractors

We coordinate with our Subcontractors responsible for aspects of clinical care delivery (e.g., dental and vision services) on an ongoing basis to ensure the quality of care they provide our Enrollees meets Humana, industry best practice, and Commonwealth contractual standards. **All clinical Subcontractors participate in our local Kentucky QIC meetings**, reporting on quality of care and utilization metrics. We evaluate Subcontractors' performance against Contract requirements, applicable HEDIS and State-specific quality measures, and utilization of subcontracted services. We maintain a bi-directional data exchange through which our Subcontractors supply us with utilization, claims, and complaints data, which we monitor for trends, disparities, and adverse outcomes tracking purposes. We also coordinate with Subcontractors through our **Joint Operating Committee (JOC)** meetings, which are designed to review the previous period's subcontractor performance as compared to the Service Level Agreements that define performance requirements and their subcontract provisions. JOC meetings include engagement by key Kentucky Medicaid operations and subcontractor

personnel. Finally, across all operations, Humana's **Subcontractor Oversight Committee (SOC)**, led by our Kentucky Chief Operating Officer (COO), Samantha Harrison, monitors performance across all Kentucky Subcontractors through the monthly Delegate Vendor Performance Summary report by all Kentucky Subcontractors. We use this report to assess:

- Subcontractors' performance
- Opportunities for improvement
- Progress in addressing corrective actions

Collaboration with Community-Based Organizations (CBO)

Given the direct effect of unmet SDOH needs on Enrollee health, CBOs play a crucial role in our efforts to engage with and empower Enrollees. CBOs participate in our QMAC, where we can coordinate with our community partners on existing and ongoing quality issues and solicit feedback on how we may better address SDOH needs. We maintain partnerships with local businesses, non-profits, educators, and government organizations to help solve identified SDOH needs such as food insecurity, transportation issues, and housing insecurity. Coordinating with CBOs within our QI structure allows us to work with our trusted community partners to address and remove socioeconomic barriers that impede Enrollees' ability to focus on improving their health.

Coordinating and Collaborating with CBOs

United Way of Kentucky and Unite Us: Humana has invested in the United Community Louisville pilot and is committed to working with United Way of Kentucky to broaden coverage of 2-1-1 across the Commonwealth. The Kentucky 2-1-1 Community Resource Directory (CRD) is powered by United Way across the Commonwealth but does not have contact centers and coverage in all counties. Through Humana's **new partnership with the United Way of Kentucky**, we are helping fund and deliver 2-1-1 services to the entire Commonwealth, with an expectation of addressing efficiency and standardization of user experience as we move forward.

KVC Kentucky: Humana will collaborate with KVC Kentucky to identify children at risk of out-of-home placement and provide them with reunification and foster care services. Providing an array of BH, substance abuse, and child welfare services, **KVC Kentucky** targets the significant problems that families face in our society. Serving more than 12,000 children and families each year, they provide in-home BH and substance abuse treatment, family preservation and reunification, and foster care services. Committed to strengthening and supporting the well-being and vitality of Kentucky's children, families, and communities, this partnership will deliver high-quality, impactful services designed to empower our Enrollees by building on their unique strengths.

a.ii.	Strategic solutions the Vendor will use in quality management, measurement, and improvement.

FULLY INTEGRATED CLINICAL MODEL

Humana deploys a **fully integrated clinical delivery model** through which we provide all Covered Services including medical, BH, and pharmacy services. Our integrated model allows for a **360-degree view of our Enrollees**, enhancing our ability to monitor, assess, and address any quality of care issues. Our integrated clinical model improves Enrollee self-management of chronic physical, BH, and intellectual disability conditions as well as SDOH needs. At the center of our integrated model is our **integrated clinical platform, Clinical Guidance eXchange (CGX)**. CGX's functionality enables the direct management of BH, social, intellectual and developmental disabilities (I/DD), and physical health services, enhancing our ability to document gaps in care,

conduct care planning, monitor plan compliance, and proactively address co-occurring needs and changes in condition. Our integrated clinical platform provides all Humana clinical associates, irrespective of specialty, the same clinical information so that the full picture of Enrollee health – rather than fragmented pieces – guides our QI efforts.

Our **fully integrated Comprehensive Care Support (CCS) team**, led by the Care Manager (CM), anchors our Kentucky Medicaid care management program. The CCS team provides an interdisciplinary forum for our associates with expertise in physical health, BH, I/DD, and SDOH needs of Medicaid Enrollees. This exchange of information and ideas supports Humana Enrollees with co-morbidities and complex needs. Our approach facilitates person-centered, whole person, and coordinated care and includes other factors that may impact our Enrollees. Through care management engagement, **our CCS team has positively impacted quality performance** by closing gaps in care, reducing costs, and supporting self-management of chronic conditions among our Medicaid Enrollees. The CCS team structure is supported by our fully integrated clinical platform (CGX), which facilitates sharing of information and communication across all the internal teams that support our Enrollees.

> **Humana's Integrated Clinical Model Improves Outcomes: Florida Medicaid 2017 to 2018**
>
> - **Diabetes: 43.4% decrease** in admits per thousand for our pediatric Enrollees
> - **Asthma: 50% decrease** admits per thousand for our pediatric Enrollees with asthma and **59.5% decrease** for our adult Enrollees with asthma

PROVIDER ENGAGEMENT

Humana develops strategic partnerships with our providers to incentivize high-quality care and drive improved outcomes. Humana's provider engagement model, led by our Provider Services Manager, Michelle Weikel, places Primary Care Providers (PCP) at the forefront of managing Enrollees' care. We also work directly with our PCP provider groups to track, monitor, and analyze quality and utilization data as well as trends. We leverage utilization and quality data to support interventions and offer **value-based provider incentives** for:

- Increasing access to care
- Increasing utilization of preventive care
- Promoting physical health and BH integration
- Reducing potentially preventable events (PPE)

Our QIAs conduct **quarterly meetings with our network PCPs to review data specific to the group, including gaps in care**. For our Kentucky Medicaid program, we use tailored provider profiling approaches to address the differences in clinical scope and the role in the delivery of

> Enrollees assigned to Humana providers in value-based arrangements in ▮▮▮▮▮▮▮

care for each provider type. Our practice of profiling is an avenue of engaging with the provider to discuss other issues, such as barriers to access to care, coordination of care, and SDOH. QIAs also **educate providers on existing gaps in care** for their Humana patients and specific utilization metrics such as potentially preventable admissions and readmissions that are affecting quality of care.

CARE DECISION INSIGHTS

Care Decision Insights is a tool that allows Humana to share information with our providers to improve their patients' care by utilizing specialists that demonstrate high efficiencies and effectiveness. Care Decision Insights encourages provider groups to consider and incorporate cost and quality insights into their referral decisions. For PCP groups, Care Decision Insights data may provide reassurance that the specialist to whom they refer their patient is not only in network but is also recognized for delivering quality, high-value care and improved patient outcomes. **Through our innovative Care Decision Insights platform, we give PCPs information about the most efficient and effective specialists in Humana's network**. For specialists, the Care Decision Insights program gives details regarding how their performance compares to that of their peers. We have found that driving referrals to specialists will incentivize them to perform better. Results of Care Decision Insights can be found in the public

Provider Directory (and in some cases directly into the provider workflow at the point of influence), allowing PCPs and Enrollees to choose their preferred providers based on their quality score. Our goal is to use Care Decision Insights to direct care to providers who have a proven track record of delivering high-value care.

QUALITY ANALYTIC CAPABILITIES

Humana's robust quality analytic capabilities provide the foundation for identifying care gaps and quality of care issues. We use several reporting tools, such as our internal and proprietary integrated care platform, CareHub, and predictive models to:

> Humana is leading efforts to standardize SDOH benchmark measurements and expectations by working with the **National Quality Forum** to define quality measures around food insecurity.

- Monitor care gaps at the Enrollee, population, and priority population levels
- Track HEDIS and State-specific measures
- Monitor the quality of care our providers deliver
- Develop appropriate quality initiatives

Humana's **multidisciplinary analytics teams** support our ongoing quality measurement, monitoring, and analysis efforts. Composed of analysts, data scientists, predictive modelers, consultants, and other associates who specialize in providing insights, these teams collaborate to supply data trend analysis to identify areas where we see improvement or where we need to focus additional strategies to improve quality of care. These teams (including **Clinical and Quality Analytics, Pharmacy Analytics, and Medicaid Trend Analytics**) help Humana develop insights that inform our clinical strategies and assist in engaging providers and Enrollees about emerging health issues. **Humana's Medicaid Severity Score Predictive Model**, a predictor of future costs over the next 12 months, is the primary predictive model we use across our Medicaid population. Using this proprietary model, we incorporate a severity score generated from medical, BH, and pharmacy claims into monthly reports identifying Enrollees with high costs and clinically complex health conditions over a rolling 12-month period. This stratified reporting allows us to intervene appropriately, including enrollment in care management, linking an Enrollee to a higher-performing PCP or addressing SDOH.

Health Disparities Data Capabilities

Humana employs various tools and approaches to identify health disparities among our priority populations. We collect, mine, and stratify Enrollee data to render actionable and targeted quality initiatives that address the root cause of health disparities. We deploy the following innovative tools and approaches to stratify Enrollees within health disparity variables:

- Healthy Days Outcomes: Humana analyzes Healthy Days data by lines of business; markets; chronic conditions; SDOH; and many demographic factors, including age, gender, race, and ethnicity. This allows for a deeper understanding of these populations and tailored interventions to address specific needs. To promote engagement and improve Healthy Days, Humana performs outreach calls to remind Enrollees about upcoming and overdue preventive health visits and as a tool for our health literacy campaigns. We intend to replicate the success of our **Referral Calls Program on Healthy Days** piloted in our Florida Medicaid market, where MSRs conducted outreach calls and engaged with 1,000 Enrollees who reported more than 20 Unhealthy Days and linked more than 30% of Enrollees interested in learning more to Humana's health improvement programs. **As a result of this proactive outreach, we saw an increase in PCP visits and a significant decrease in Unhealthy Days for the Enrollees we reached. We will duplicate the success of this program for our Kentucky population**.
- Humana's Clinical and Quality Analytics Teams: Our clinical and quality analytics teams identify trends in HEDIS performance by race, ethnicity, gender, language(s) spoken, and geographic location that may indicate disparities in health outcomes.
- GEOSCAPE: We use GEOSCAPE's tool to view ethnicity, country of origin, and language data at the zip code level to better understand the cultural environment and deploy the appropriate intervention.

a.iii.	Innovative strategies and enhanced services, if any, that the Vendor proposes to implement to enhance the health and well-being of Enrollees and to improve health outcomes, including examples of successes with similar Medicaid populations.

INNOVATIVE STRATEGIES

Innovative Strategy #1: Enrollee Incentives

In our experience serving Medicaid populations, Humana has found that to drive behavior change among our Enrollees, we must educate them on the importance of preventive services, ensure access and availability of the appropriate level of care, and reward them for that behavior change. We offer **Enrollee incentives to encourage access to preventive services** (according to the appropriate periodicity schedules) and **reduce the use of low-value care such as emergency department (ED) visits for primary care-treatable conditions**. Our practice of incentivizing healthy behaviors fosters long-term positive impacts on Enrollee health and helps empower Enrollees to engage in and improve their health.

Go365's Success: 2016-2018

6% Lower healthcare costs in Year 1

10.1% Even lower costs by Year 3

56% Fewer ED visits

37% Fewer hospital visits

We use our state-of-the-art **digital wellness platform Go365**, a platform that has demonstrated success in improving health outcomes, to engage Enrollees in improving their health. It incorporates practices of **behavioral economics** that encourage and reward Enrollees to complete healthy activities. The Medicaid Go365 mobile application will be live for Kentucky Enrollees with a customized experience specific to their needs and identified incentives for our Kentucky Medicaid Enrollees and priority populations. Go365 allows **Enrollees to earn and receive gift cards** (pursuant to Kentucky and federal guidelines) through mail or real time via email for wellness activities such as exercise and health coaching. We will incentivize Kentucky Enrollees for the following specific behaviors:

- Prenatal exams and postpartum visits
- Well-Child visits
- Completion of education on when to access the ED (level of care education)
- Diabetes screenings/exams
- Annual flu vaccination
- Annual preventive care visit
- Child completion of dental visit
- Health Risk Assessment (HRA) completion
- Completion of recommended mammogram and cervical cancer screenings

How effective are incentives in encouraging preventive care?

In a pilot project involving more than 600,000 Humana MA Enrollees, we found almost 50% of the preventive services rewarded showed a statistically significant impact in influencing behavior.

Specifically, Go365 will be used to promote:

- Health management: Go365 will reward Medicaid Enrollees for engaging with certain health coaching programs. Coaching will address health topics like weight and stress management, tobacco versus smoking cessation, and healthy eating habits.
- Wellness promotion and education: Go365 will promote Medicaid-specific wellness initiatives to maximize Medicaid Enrollee participation. It will also include educational materials and webinars for Enrollees to access on topics such as the importance of scheduling preventive visits and how to access additional benefits such as transportation.
- Real-time rewards: For certain services, like the flu shot, Go365 enables Enrollees to self-report through verified document completion of an activity to receive a reward versus waiting on a claim to be processed.

Innovative Strategy #2: Closed-Loop Community Referral Platform

To improve outcomes through closing gaps in SDOH needs, Humana is engaging in a pilot in Louisville to develop a connected, collaborative, community-wide system to coordinate care and services across sectors. This tool will aim to address all SDOH education and offer real-time tracking and reporting using **Unite Us** (the vendor selected by Metro United Way, the Louisville Health Advisory Board, and other community partners for the United Community Louisville pilot). Using United Way's 2-1-1 as the Community Resource Directory (CRD), **the United Community Louisville pilot is testing a referral process and platform** that will create a "no wrong door" system that links information across health, education, and human services sectors, including **tracking of outcomes after making referrals** to services. This platform creates additional capacity in the community to enable electronic referrals to community services, get real-time updates on the status of the referral and outcomes, and build these data into our population health management (PHM) strategy and care management processes.

Innovative Strategy #3: Digital Enrollee Messaging

Humana deploys **digital and mobile interventions** to engage our Medicaid Enrollees across multiple channels. Currently 760 of 774 zip codes in Kentucky have cellular coverage by at least one carrier, and nationally, 87% of Medicaid customers own a smartphone. With almost one-half (49%) of Kentuckians living in rural areas[2], we can meet Enrollees where they are through myHumana (accessible via our mobile application and our web-based Enrollee portal) and through our text messaging functionality. **This regular contact keeps Enrollees engaged in managing their health**.

Through myHumana, we send gap in care alerts and several reminders for services including but not limited to annual flu shots, multiple required cancer screenings, medication refill and adherence, prenatal and postpartum care, and diabetes and other disease-specific screenings. Additionally, every year Humana pushes out annual wellness and flu shot reminders, as well as notifications of eligible incentives, to all of our Enrollees through text messages that are free to end-user. For eligible Enrollees, a Tracfone with expanded data and minutes is provided so our most vulnerable Enrollees can be empowered to engage in their healthcare.

> From January to August 2018, we **closed 1.6 million clinical care gaps** and **sent 30.4 million personalized messages** across our lines of business using CRM.

We use our clinical rules engine, Anvita, and predictive algorithms built around our clinical technology platform, CareHub, to develop **targeted clinical messaging for our Enrollees**. Our Customer Relationship Management (CRM) tool integrates CareHub data to personalize our Enrollee messages so they include topics most relevant to them. We can then use CareHub information to prioritize an Enrollee's health needs so that CRM sends personalized messages via text messaging, our Enrollee portal, or during communication with an MSR in a sequence that aligns with the urgency of those needs. The scope of our digital solutions is discussed in sub-question I.C.9.a.iv of the Request for Proposal (RFP).

ENHANCED SERVICES

Humana has developed enhanced services (Table I.C.9-1) designed to engage Enrollees in their care and to improve outcomes.

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[2] https://www.kff.org/medicaid/fact-sheet/medicaids-role-in-kentucky/

Table I.C.9-1: Enhanced Services to Drive Improved Outcomes

Enhanced Service	Description
Comprehensive Care for Pregnant Women Navigating Substance Abuse	We build strong relationships with OB/GYN offices through our dedicated Provider Relations representatives to **encourage care management referrals for pregnant Enrollees and particularly those with substance use disorder (SUD), a history of domestic violence, and/or tobacco use**. In addition to engaging these Enrollees in our MomsFirst program, we help these Enrollees engage with the KY-Moms Maternal Assistance Toward Recovery (MATR) program at their local Community Mental Health Center (CMHC). Our MomsFirst care management program will work alongside the KY-Moms MATR specialist to promote access to treatment and behavior change for eligible Enrollees. As a result of participation in our MomsFirst care management program, as well as in our Neonatal Abstinence Syndrome (NAS) care management program, in our Florida Medicaid program we saw **neonatal intensive care unit (NICU) admissions per thousand decrease by 7.4% from 2017 to 2018 and average length of stay decrease by 2.4% from 2017 to 2018**.
Telehealth Services	We use telemedicine and telepsychiatry for physical health and BH needs aimed at increasing preventive services and decreasing ED visits. Enrollees have access to a) **Virtual 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, through a virtual interaction, a licensed therapist face-to-face from the comfort of their own home.
Provider-to-Provider Telepsychiatry	We provide **real-time ED psychiatric consultations** for facilities without an affiliated psychiatric unit. We also offer **PCP-led telepsychiatry** consults in the office if needed.
Medication Refill Concierge	Increased adherence to medication, particularly for chronic conditions, reduces potential admissions and readmissions. Humana's **Enrollee outreach program improves medication adherence for targeted medications** through live or voice activated technology (VAT) outbound calls that facilitate medication refills for chronic conditions including but not limited to diabetes and hypertension, hyperlipidemia, and asthma.

Table I.C.9-1: Enhanced Services to Drive Improved Outcomes

Enhanced Service	Description
School-Based Services	Childhood Immunizations: The Commonwealth significantly lags behind the nation with respect to child immunizations. Humana has made concerted efforts (such as raising awareness at kindergarten and middle school open houses and through our digital Enrollee messaging) to increase vaccinations among our Enrollees. To ensure greater access to immunizations, **Humana is committing to a $50,000 grant for each of the eight Kentucky regions where we will partner with a hospital system and/or community-based healthcare system to offer school-based vaccination and wellness initiatives.** This sponsorship will increase access to (and compliance with) immunizations for our Enrollees by: • Identifying and targeting eligible Humana Enrollees in schools • Encouraging participation through school outreach and collecting parent/guardian consent • Delivering vaccinations in the school setting in a scheduled and non-disruptive manner Virtual care enhanced preventive visits: School-based telehealth programs can be an impactful way to improve health outcomes for children. With new telehealth technology, special computer-connected otoscopes and stethoscopes allow doctors to check ears, noses, throats, and heartbeats from remote locations. These innovative programs improve access to care and perhaps more importantly, they offer convenient access to care. In an effort to improve access to care for Kentucky children, **Humana is supporting the advancement of Norton Healthcare's school-based telemedicine program in Jefferson County Public Schools**. Humana will sponsor the telemedicine technology, which Norton Healthcare uses to remotely examine the student with the assistance of the school nurse. This support will allow expansion of telemedicine technology in public schools located in underserved areas, reducing disparities in access to care while improving the overall health of the community. Humana and Norton Healthcare see this as an opportunity to keep children in school, healthy, and learning.
Medical Respite	Humana has developed a comprehensive **medical respite pilot program to support our Enrollees experiencing homelessness** with post-acute medical needs, with the goal of reducing healthcare costs and mortality risk. Our strategy is informed by conversations with CBOs experienced in covering medical respite care and the advice of leading experts in the field of medical respite, such as the National Health Care for the Homeless Council. Our program will offer and test outcomes for **temporary post-acute medical respite beds** and evidence-based low-barrier medical care, nutrition support, BH care, and social supports. We will incent our CBOs to include wraparound services that promote long-term stability through supports such as tailored education, skills and independence training, and transitions to long-term housing, increasing the likelihood of **preventing future homelessness**.

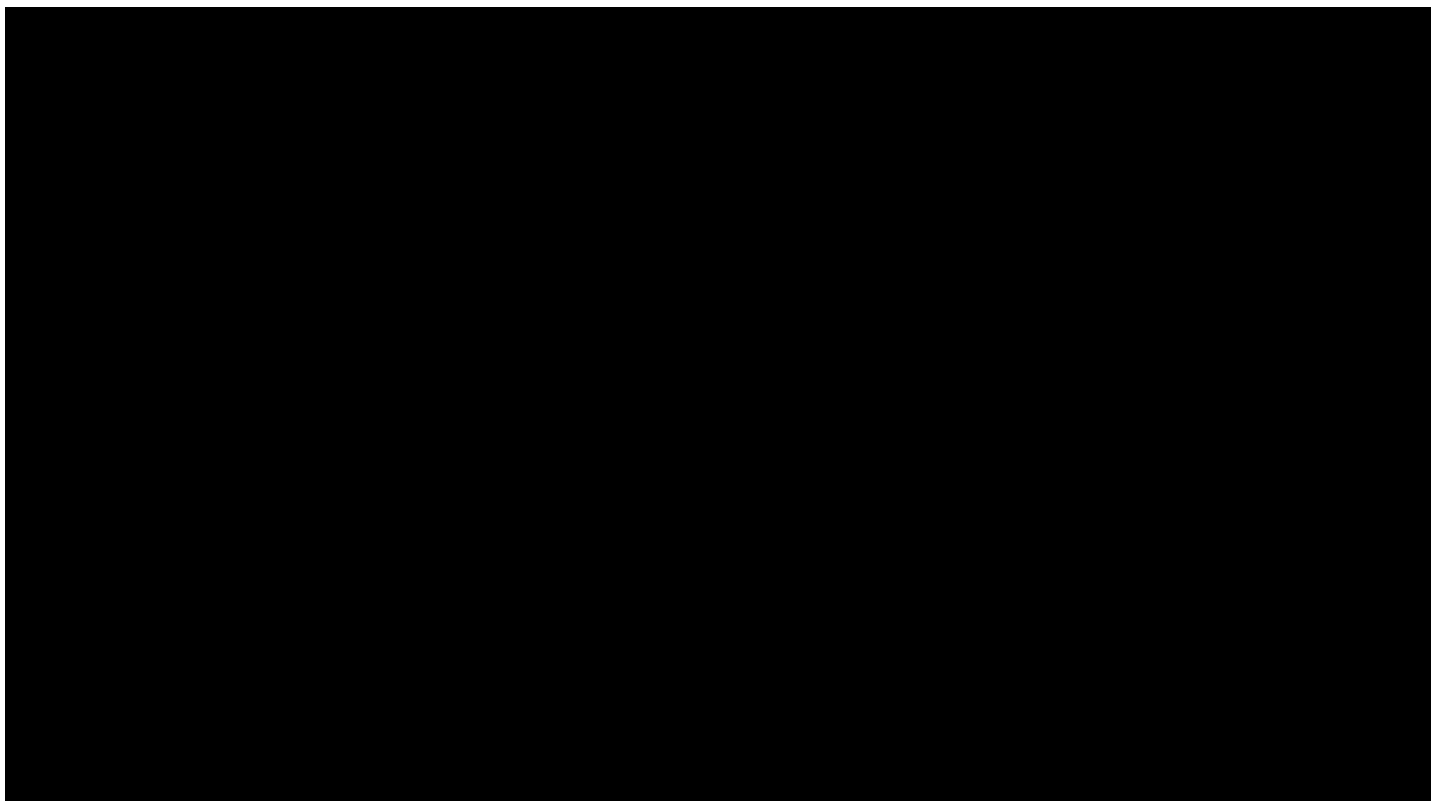| a.iv. | Internal tools and technology infrastructure the Vendor will use to support improvements in health outcomes and to identify, analyze, track, and improve quality and performance metrics as well as the quality of services provided by Network Providers at the regional and statewide levels. |

CLINICAL TECHNOLOGY PLATFORM

Humana uses CareHub, our internal and proprietary integrated set of tools, to monitor and track health outcomes and utilization for Enrollee populations. CareHub integrates Enrollee data from a variety of sources including claims, HRAs, biometrics, personal health profiles, and lab and test results through our clinical platform, CGX (Figure I.C.9-2). CareHub supplies enhanced capabilities to our CCS team to identify candidates for programs, document gaps in care, optimize care planning, monitor plan compliance, and identify areas for improvement.

CareHub's advanced data analytics and predictive modeling functionality, which can run more than 100 clinical models, allows Humana to identify high-risk Enrollees for engagement in tailored, localized care management and programs for Management of Chronic Conditions. These all connect to our administrative infrastructure via a common set of claims and enrollment platforms, completing a comprehensive holistic approach to Enrollee data sharing and accessibility.

Figure I.C.9-2: Humana's Clinical Data Infrastructure

QUALITY INFORMATION TECHNOLOGY (IT) INFRASTRUCTURE

Humana achieves systematic measurement and assessment of performance using multiple data systems. We evaluate these systems annually to verify that we have adequate resources to meet the needs of the program. We use the following tools and technology to support quality:

Table I.C.9-2: Quality Reporting and Analytics Tools

Report	Description
Enterprise Data Warehouse (EDW)	EDW houses Enrollee- and claim-level data and is one of the largest data sources used for quality and clinical analytics activities.
Rules Engines (Cotiviti/Anvita)	Cotiviti serves as the official source of truth for Humana's HEDIS results and HEDIS rate progress throughout the year. With each monthly refresh of HEDIS rates, HEDIS Enrollee-level detail tables are generated and sent to EDW where they are also used for operational progress reporting and clinical/quality analytics. Anvita is Humana's internally managed clinical rules engine that allows us to generate care gap reporting on a more frequent basis in order to source Enrollee alerts, predictive models, and provider reporting on open care gaps and needed preventive services. It also supports our rapid-cycle QI activities.
Predictive Models	Predictive models are used to anticipate individual Enrollee behaviors and proactively intervene, usually via outreach and engagement.
Business Intelligence (BI) Tools	Humana uses multiple BI tools to observe and analyze many subsets of the quality landscape. From simple Excel dashboards to complex QlikView and Tableau reporting portals, we monitor and analyze performance via root cause analysis and with the ability to slice and manipulate data for areas such as BH, population health, pharmacy, UM, provider-level reporting, cohort- and demographic-level reporting, clinical and operational process monitoring, etc.
HEDIS Dashboard	Our HEDIS dashboard serves as our internal Medicaid reporting tool. Updated monthly, it aggregates Medicaid Enrollee data, provides data at an Enrollee-level detail, and helps define populations for pilot campaigns. This dashboard includes all HEDIS measures and sub-measures on which we report and trend performance, including a prior three-month trend and our performance relative to the 50th and 75th percentile bands, in order to monitor and assess progress on any measure. The dashboard can be filtered by market, region, demographics, etc. to identify specific performance disparities.
State Priority Reporting	Our strategic State Priority Reporting is designed to track quality and other outcome measures required within the Draft Medicaid Contract. These reporting capabilities allow continuous monitoring of measures required by the Department and facilitate both required reporting as well as identification of our QI opportunities.
UM Operational Dashboards	We produce operational dashboards and reports that aggregate data in an actionable format to help identify Enrollees who are at high risk for high-cost utilizations. Please refer to our response in Section I.C.10 Utilization Management of the RFP for more information.
Care Management Operational Dashboards	We track HRA completion rates, re-assessments, and care management activities via our care management operational dashboards.

Table I.C.9-2: Quality Reporting and Analytics Tools

Report	Description
3M PPE Suite of Tools	Our Medicaid Trend Analytics team utilizes the 3M PPE suite of reporting products to complement the Early Indicator Report (EIR) used to assess admissions, readmissions, and ED visit trends. This suite provides additional insights into utilization trends, identifies potential preventable events, and creates reporting consistency across all of our Medicaid programs.

Humana has direct connections built eight of the leading electronic health record (EHR) software systems (including Epic, Allscripts, eClinicalWorks, and Athena Health) to facilitate the timely transfer of clinical data into EDW that supports identifying and closing gaps in care, as well as our efforts to monitor, track, and improve HEDIS measures. These connections provide near real-time clinical data via continuity of care documents (CCD) from our network providers, as well as Admission, Discharge, and Transfer (ADT) notifications, if the vendor is capable.

MONITORING PROVIDER QUALITY OF CARE

To support providers as they work to improve health outcomes and the overall Enrollee experience, Humana uses data analytics to build multidimensional reports from our proprietary **Compass** tool. We have developed this sophisticated suite of tools to compare provider performance against both nationally recognized clinical standards and their local peers. Compass uses metrics to **evaluate provider performance on access to care, delivery of preventive services, adherence to treatment, and medication and management of complex conditions**. Through these reports we seek to provide a fair and accurate representation of how providers are meeting evidence-based standards of care. QIAs work closely with each practice's clinical team to interpret the reports and develop action steps to **improve quality, close gaps in care, and meet VBP targets**.

We deploy **QIAs** to provider offices to educate on existing gaps in care for their Humana patients and discuss specific utilization metrics such as potentially preventable admissions and readmissions that are affecting quality of care. QIAs deliver provider-specific performance reports including but not limited to near real-time updates on patient ADTs, HEDIS details on analysis of gaps in care and opportunities for improvement, and analyses of prescription drug utilization including adherence estimates.

We also monitor provider **adherence to CPGs** to evaluate provider adherence to evidence-based clinical guidelines. Our CPG adherence processes is described in detail in sub-question I.C.9.I.2 of this response.

a.v.	Methods to ensure a data-driven, outcomes-based continuous quality improvement process, including an overview of data that is shared with providers to support their understanding of progress in achieving improved outcomes.

QUALITY OPERATIONS SUPPORTING CONTINUOUS QUALITY IMPROVEMENT

Humana has built strategies within our quality operations to support CQI. At each **monthly QIC meeting**, co-chaired by our Medical Director Dr. Galloway and our QI Director Ms. Summers, operational areas report on specific quality metrics using report templates to ensure we review and discuss barriers, analysis, trends, and progress toward goals. We incorporate network provider feedback on our QM/QI processes via network participation in our QIC. These **operational areas continuously monitor and track quality metrics** via data listed above within their day-to-day operations and then report back to the QIC to facilitate organization-wide approaches to closing gaps in care delivery and quality.

Our Medicaid Quality Initiative Governance Committee oversees all Medicaid quality improvement and performance, goals or benchmarks, strategy, and performance improvement efforts across our organization. This centralized approach to QI facilitates best practice-sharing and collaboration among all Medicaid plans and business areas to promote an organization-wide approach to analyzing potential care gaps and developing new quality initiatives. The Quality Initiative Governance Committee uses multiple dashboards and reports to monitor our performance and **meets monthly** to discuss findings. For underperforming areas, we dispatch taskforces to conduct root cause analysis, implement QI efforts, and report back to our Medicaid Quality Initiative Governance Committee. This continuous approach ensures the consistent delivery of high-quality care to our Enrollees.

> A Humana Performance Improvement Project (PIP) subcommittee **reviews PIP data every other month** to determine the effectiveness of interventions. This progress is reported to and reviewed by our QIC and Quality Initiative Governance Committee.

Annually, our QIC convenes to identify QI areas for the upcoming year. These areas are outlined in our **QIWP**, which specifies activities to be undertaken in the upcoming year and includes goals and objectives based on the strengths and weaknesses identified in the previous year's annual evaluation report. Throughout the year, **we frequently monitor and assess our performance toward meeting performance targets** and update our QIWP accordingly.

Finally, our **Quality Improvement Evaluation (QIE)** is an annual written evaluation of the previous year's QI Program. The **QIE is a data-driven, outcomes-based assessment** of the effectiveness of our QI program and its impact on Humana's PHM strategy. We evaluate quality of service by monitoring issues such as access and availability, Enrollee satisfaction, Enrollee grievances and appeals, and reasons for grievances and appeals. We design QI activities and clinical initiatives for various age groups and Enrollee populations. The QIE outlines accomplishments, analyzes data and outcomes compared to goals, identifies limitations or barriers to meeting objectives, and provides conclusions and recommendations for the upcoming year. It addresses the structure and function of the QI program, processes in place, and the outcomes or results of QI activities.

CONTINUOUS QUALITY IMPROVEMENT METHODOLOGY

Humana's CQI approach relies upon our robust set of actionable operational metrics, clinical dashboards, analytics tools, and our quality and analytics teams. This array of data reporting and monitoring allows us to identify opportunities for improvement, establish baselines, monitor ongoing clinical outcomes, and track progress against industry measure sets [HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), PPEs] to benchmark our performance against peers, ourselves, and national averages.

We employ **CQI strategies** to ensure we are monitoring outcomes on an ongoing basis. Through our CQI approach, we execute a planned sequence of systematic and documented activities aimed at both resolving identified variances and improving processes. We regularly employ the following processes to identify quality of care issues, care gaps, and health disparities in outcomes:
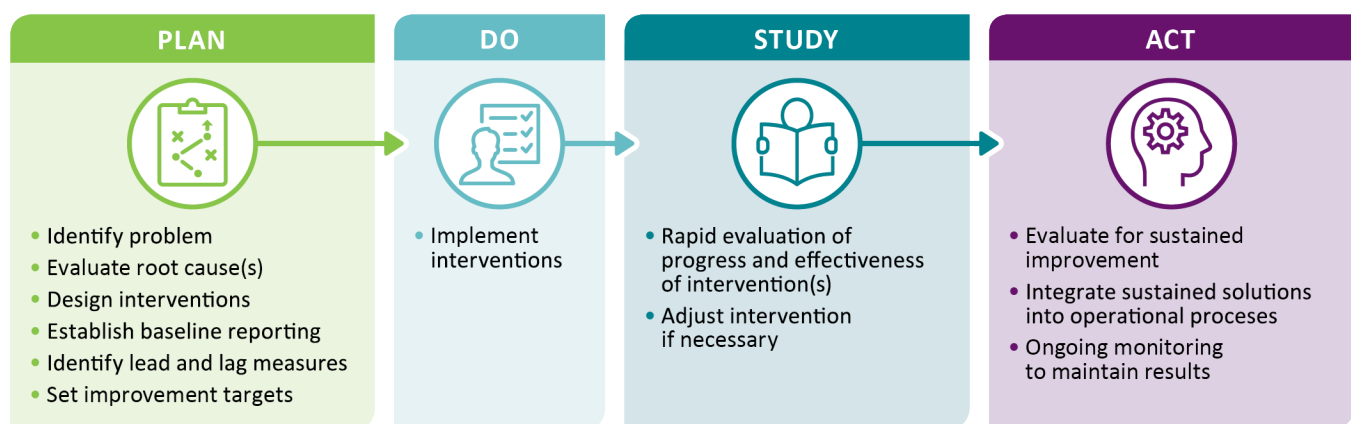
- Incorporation of Enrollee demographics (including clinical, geographic, racial, ethnic, gender, and cultural) across all quality performance analytics to identify high-risk populations, areas of network need, Enrollee education opportunities, and performance improvement opportunities
- Analysis of access and availability issues, including after-hours availability of PCPs
- Analysis of continuity and coordination of care activities
- Review of other non-clinical areas of performance (such as Member Services Call Center statistics, additional Enrollee Services functions, marketing and outreach, claims processing timeliness and accuracy, and Enrollee and provider satisfaction)

Once we have identified gaps in care delivery, quality of care issues, and/or disparities in health outcomes, we deploy **root cause analysis** to identify why an issue occurred. Humana sees root cause analysis as a crucial part of our QI process, allowing us to fully understand an issue and create a targeted solution to resolve the issue and prevent recurrence. Our Kentucky QIC and Quality Initiative Governance Committee review trends and root cause analyses from operational areas and provide a cross-functional forum to develop solutions.

Plan-Do-Study-Act

Our approach in developing, maintaining, monitoring, and adjusting clinical and non-clinical initiatives stems from the **Plan-Do-Study-Act (PDSA)** data-driven improvement cycle (Figure I.C.9-3) that includes **rapid-cycle improvement methods** and **use of lead and lag measures**. This approach, paired with our monthly quality analytics reporting and evaluation, maximizes the PDSA cycle and drives material improvement as we determine if interventions are producing the desired results. In cases where interventions are not producing desired outcomes, we are able to conduct a rapid root cause analysis and adjust our interventions accordingly.

Figure I.C.9-3: Plan-Do-Study-Act (PDSA) Process

PLAN	DO	STUDY	ACT
• Identify problem • Evaluate root cause(s) • Design interventions • Establish baseline reporting • Identify lead and lag measures • Set improvement targets	• Implement interventions	• Rapid evaluation of progress and effectiveness of intervention(s) • Adjust intervention if necessary	• Evaluate for sustained improvement • Integrate sustained solutions into operational processes • Ongoing monitoring to maintain results

Our QI process identifies interventions that produce long-term and sustained results. We incorporate interventions that demonstrate both improved outcomes and sustainability into our operations – updating policies and procedures while continuing to monitor for sustainability of the improvement.

PROVIDER ENGAGEMENT IN CQI

Humana sees our network providers as partners in our CQI processes. We share actionable data with our providers to supply them with the information they need to drive quality outcomes, improve patient experience, and improve population health. We align our provider performance reporting with DMS Quality Program priority metrics and use these metrics to evaluate provider performance on access to care, delivery of preventive services, adherence to treatment, and medication and management of complex conditions.

We share the following data with our network providers:

- HEDIS metrics
- EPSDT metrics
- State-specific metrics
- Adult/Child Core Set metrics
- Utilization metrics and performance against PPE measures
- ADT data
- ED utilization data
- Compliance with CPGs
- Pharmacy data
- Care Plans
- Enrollee satisfaction data, including grievances and appeals
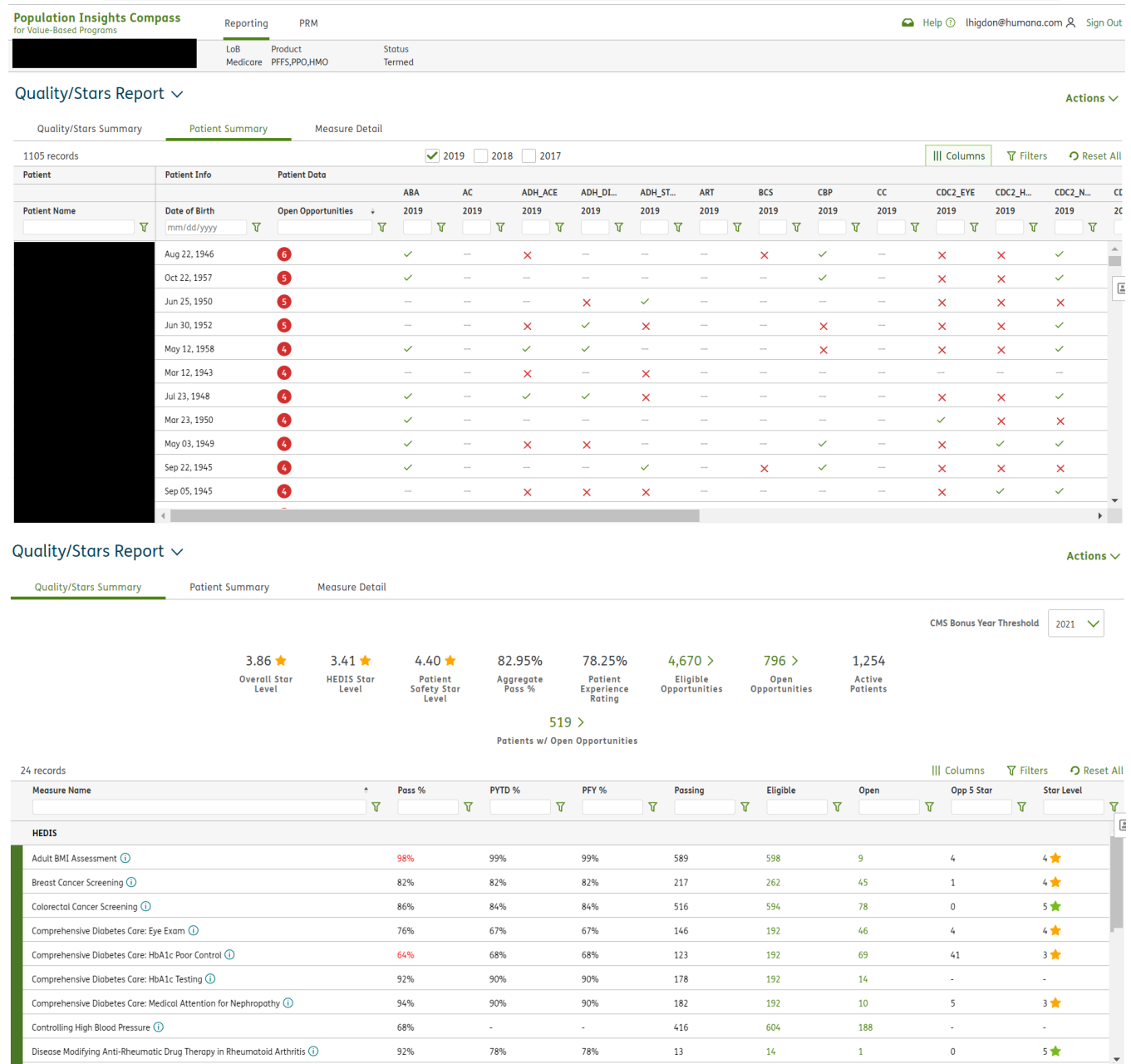
For each selected measure, we share the following information:
- Performance relative to the measure benchmark
- Improvement needed to meet the benchmark if the provider falls below the benchmark

- Quality trends measuring current performance against past period performance
- Performance relative to the top 10% of providers in our network for each individual measure

Our proprietary **Compass** tool compiles utilization, financial, and clinical data that can be filtered to enable providers to identify patients or groups requiring additional support. These expanded population health data help our providers manage the health of their patients and better inform their outreach and care. Compass draws upon CareHub data to provide an integrated view of gaps in care, services, and needs across the provider's patient panel into actionable reports. Continuous monitoring and reporting at the State, regional, and physician levels enable providers to easily identify patients and/or groups requiring additional support.

Figure I.C.9-4: Humana's Compass Quality Reporting Capabilities

Our **provider-facing QIAs** also work with our providers to educate on high utilization trends and HEDIS/quality performance trends, Enrollee experience best practices, and CPGs. Our QIAs are responsible for supporting value-based care initiatives at our physician practices. They share population health performance reporting and integrate Humana clinical programs and resources into practice workflows to optimize patient care, improve the provider experience, and enhance quality of care.

b.	Indicate if the Vendor has received NCQA accreditation for the Kentucky Medicaid market, and if not, the proposed timeline for achieving accreditation.

Humana has been an NCQA-accredited health plan in Kentucky since 2016. Our current accreditation is active and valid through November 2022. We recently completed the renewal process for NCQA full accreditation and received our full accreditation status notification in November 2019.

Upon execution of the Contract, Humana plans to pursue the **NCQA Distinction in Multicultural Health Care**, as this aligns with our values and enterprise goals and reinforces our core mission of ensuring equitable access to care for all Enrollees.

In compliance with Section 19.1 of the Draft Medicaid Contract, Humana authorizes the accrediting entity to provide the Department its most recent accreditation review, including accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans (CAP), summaries of findings, and expiration date of the accreditation.

Please refer to **Attachment I.C.9-1 Accreditation Certificate Kentucky Medicaid** for more information.

c.	Provide the Vendor's proposed use of the Quality Improvement Committee (QIC) to improve the Kentucky Medicaid managed care program.

Humana's Kentucky QIC is our state-based quality committee dedicated to overseeing the overall quality program and ensuring QI activities take place throughout our organization. Co-chaired by our Kentucky Medical Director Dr. Lisa Galloway and our Quality Improvement Director Ms. Summers, our Kentucky QIC **meets monthly**, and will direct and review all QM/QI activities, **facilitating comprehensive integration of quality and operational processes across physical health and BH services** by analyzing and evaluating QM/QI activities. The QIC offers a vehicle to provide bi-directional feedback between operational leaders and Quality leaders with the ultimate goal of improving quality for our Enrollees. Because of the multidisciplinary nature of the committee, operational leaders can receive feedback on problems and assistance with ideas to resolve barriers that may not be possible without the Committee's support.

> Humana's QIC will meet and exceed the requirements outlined in Section 19.2.A of the Draft Medicaid Contract.

The QIC is the forum through which we monitor our progress toward the QI goals laid out in our QIWP. At each QIC meeting, all operational areas report on specific quality metrics using report templates to ensure we review and discuss barriers, analysis, trends, and progress toward goals. **Attachment I.C.9-2** contains Kentucky QIC meeting minutes from a 2019 Humana-CareSource QIC. We incorporate network provider feedback on our QM/QI processes through network provider participation on our QIC. We maintain a comprehensive representation of voting members, including our Medical Director, BH Director, PHM Director, QI Director, and QAPI Coordinator. These operational areas continuously monitor and track quality metrics and report back to the QIC to facilitate organization-wide approaches to closing gaps in care delivery and quality. The Kentucky QIC reports to the Humana Corporate QIC, which monitors and oversees QI activities across the entire Humana organization.

Using the QIC to Improve Quality of Care and Outcomes

In our Illinois Duals Demonstration program, our QIC expressed concerns about the HEDIS rate for 30-day Follow-Up After Hospitalization for Mental Illness measure. Our BH partner analyzed the first half of 2018 data for the top providers who were non-compliant with the 30-day Follow-Up After Hospitalization for Mental Illness measure. It was determined that focused training and education were needed for those providers; therefore, our BH partner implemented a training schedule. Following the enhanced trainings and education for these providers, we saw **the rate for 30-day Follow-Up After Hospitalization for Mental Illness increase from 30.23% in Q1 to 47.45% in Q3**.

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d.	Provide the Vendor's proposed use of the Quality and Member Access Committee (QMAC) to improve the Kentucky Medicaid managed care program, including the following information:

The Humana QMAC is charged with providing our Enrollees an open forum to bring issues and concerns to our attention; all Enrollees are welcome to attend QMAC meetings. Specifically, our QMAC reviews and comments on various quality and access activities, educational activities, and materials related to services on areas such as:

- Benefits
- Care management
- Provider access issues
- Health education, including healthy living within the home and community
- Cultural competency
- Employment
- Communication
- Claims issues
- Grievances and appeals processes
- Other matters impacting Enrollees and their representative

These Enrollee-driven meetings will be co-chaired by Mr. Kennedy, our Culture & Community Engagement Director, and an Enrollee and occur on a quarterly basis.

> Humana's QMAC will comply with Section 19.2-B of the Draft Medicaid Contract.

We use Enrollee feedback from QMAC meetings to drive QI for our Enrollees. For example, at one of our Kentucky QMAC meetings, we received feedback from two of our Enrollees regarding the lighter gray color of our print selection used within our Enrollee Handbook. The Enrollees advised they had difficulty reading the information and suggested using a darker color for the text. Discussion regarding the text color ensued with those in attendance expressing concern that those with slight or significant visual impairment would have difficulty reading the document. We shared the recommendation to darken the text with our Marketing Team, who subsequently updated the Enrollee Handbook print color to a darker gray/black. This example illustrates the importance of idea exchange and how it allows Humana to improve processes, develop sensitivities to anticipate Enrollee needs, and construct methods that aid our Enrollees in overcoming challenges they face, as well as the challenges we face serving our Enrollees.

d.i.	Proposed stakeholder representation

To foster dialogue among our Enrollees (and to ensure it is Enrollee-driven), we propose the following stakeholder representation:

- Humana Enrollees, their families, and their caregivers
- A Humana Kentucky Medicaid leadership associate, such as our Kentucky Medicaid Culture & Community Engagement Director

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- A care management representative (we have found it valuable to have an associate at each meeting. Frequently, if an Enrollee has an issue, the care management associate can immediately address the issue at the meeting)
- Community Health Workers (CHW)
- Associates from our Quality Operations team, BH team, and Kentucky Operations team
- Dental Subcontractor
- Transportation Subcontractor
- State Ombudsman Program associate
- Representatives from other functional areas when voiced by Enrollees
- CBO representatives

> Our fourth quarter QMAC meeting had eight Enrollees in attendance, the largest participation in 2019.

In addition, Humana will make an effort to **ensure meetings are accessible, attended by a diverse and inclusive body**, and promoted through the following:

- Connecting with care management associates for suggestions on Enrollees who would be strong and engaged advocates of our Medicaid population so we can make direct outreach
- Holding meetings in a variety of community locations that are regionally located to ensure access across the Commonwealth
- Advertising our upcoming QMAC meetings via our provider offices, Humana website, and mobile applications and translating advertising materials into the top three languages spoken in the region
- Providing foreign language interpreters or translators, including American Sign Language, if needed

d.ii.	Innovative strategies the Vendor will use to encourage Enrollee participation.

Humana understands unmet social needs often hinder Enrollees from engaging effectively with their health plan. We want to make attending Humana events, particularly our QMAC, easier for our Enrollees. We will conduct the following activities to encourage participation in QMAC meetings:

- Provide information on the QMAC meetings on our Enrollee website, including the schedule of upcoming meetings, incentives for attending, and how Enrollees can be involved in their health plan
- ██████████████████
- Healthy meal and/or refreshments
- Reimbursement for transportation expenses incurred while traveling to and from meetings
- Child care voucher
- Allow Enrollees to identify the best day and time of the week to have meetings (we have had success during the lunch hour).

> In the third quarter of 2019 we ████ ████ ██████████████████ ██████████████████ ████████ As a result we saw attendance more than double (from three Enrollees to eight Enrollees) in our fourth quarter QMAC meeting.

d.iii.	Examples of successful strategies the Vendor has implemented to obtain active participation in similar committees.

Through our more than 20 years of experience hosting Medicaid Enrollee-focused advisory groups, we have found the following strategies effective in obtaining active participation:

Strategies used in our Kentucky Medicaid program:

- Recruit an interested Enrollee (one who attends the majority of meetings) to serve as co-chair and provide them support to learn the role.
- Provide attendees follow up on how we are using feedback received at previous meetings.
- Ask CMs for recommendations on Enrollees who might be interested in attending.
- Select appropriate locations in close proximity to where large groups of Enrollees live. For example, we have found large facilities overwhelm our Enrollees. Because of this, we have moved our meetings to smaller facilities, which make Enrollees feel more comfortable.
- Have a care management associate at each meeting to immediately address any concerns, showing Enrollees the value of attending our QMAC.

Examples of Successful Strategies from our Kentucky QMAC

To promote attendance at our Kentucky QMAC meetings, Humana works with CMs and/or CHWs who are embedded at a Federally Qualified Health Center. For example **Park DuValle Community Health Center** allows us to host our **Louisville** QMAC at their facility. We have an embedded CHW at this facility, so when our QMAC is scheduled, we notify her, and she invites and reminds our Enrollees when the meeting is taking place. In the past we have seen Enrollees attend due to this outreach.

Additionally, our meetings often take place at our community partners' locations. For example, in **Lexington** we host QMAC meetings at the cafeteria of **The Hope Center**, a homeless shelter and recovery center. In **Ashland**, we utilize **The Neighborhood**, which provides multiple homeless services including a food pantry, clothing, hot meals, etc. In **Owensboro**, we host at the **Pitino Shelter**, which is also a homeless shelter and recovery center.

We also ensure all meeting locations are located on bus lines, are compliant with the Americans with Disabilities Act, and are accessible and open to all of our Enrollees who wish to attend.

Strategies used in other Medicaid programs for similar committees:

- Allow Enrollees to identify the best day and time of the week of to have meetings (we have had success during the lunch hour).
- Offer web-based/teleconference capabilities and/or coordinating meetings at multiple remote locations (i.e., we will offer a remote site at CBOs where Enrollees can attend via teleconference).
- Contact all Enrollees who accepted a meeting invitation to offer assistance with transportation if needed.
- Make follow-up calls to Enrollees who have not responded to the invitation and live in the general area where the meeting will be held.
- Maintain regular contact between meetings with Enrollees who regularly attend to keep them engaged.
- Have the transportation Subcontractor attend to field any questions or issues Enrollees may have; Enrollees have expressed transportation instructions can be difficult to follow. Not only has this decreased transportation complaints, but this helps Enrollees find value in attending QMAC meetings.

We will implement our successful strategies outlined above in our Kentucky Medicaid program under the executed Contract.

e.	Provide a comprehensive description of the Vendor's proposed Quality Assessment and Performance Improvement (QAPI) Program that meets all requirements of this Contract.

Humana's long and diverse history in care delivery, health plan administration, provider engagement, and community integration gives us a unique set of perspectives that have supported and enabled industry progression toward new and exciting kinds of integrated care with the power to improve health and well-being and lower unnecessary costs. Humana's evolution has maintained a constant goal of driving better quality of life for our Enrollees and communities at large and is closely aligned with NCQA's Triple Aim of better health, better care, and better value.

We use our QAPI program to improve health outcomes and in doing so, is focused on the distribution of those outcomes across key sub-populations. Our QAPI program helps identify delivery of care and quality gaps, areas for improvement in condition management, and key drivers of disparities in health outcomes among our Enrollees.

The Humana QAPI program monitors, analyzes, evaluates, and facilitates improvements in the delivery and quality of healthcare services for Humana Enrollees, including those with special health care needs. We base our QAPI program structure upon DMS and federal regulations, DMS Contract requirements, accreditation standards, national healthcare agency guidelines, and organizational values. Key components of our QAPI program include but are not limited to:

> Humana's QAPI Program will comply with Section 19.3 of the Draft Medicaid Contract.

Table I.C.9-3: Components of Humana's QAPI Program

Component	Description
Organization-wide approach to QI	• QI measurement throughout all operational areas • Thorough approach to CQI; monitoring; and **analysis of medical, BH, and pharmacy services'** quality of care • Local **Kentucky QIC, a multidisciplinary committee** that includes our Kentucky Medicaid Medical Director, Medicaid BH Director, and representatives from cross-functional areas • Written policies and procedures for **CQI** are developed and assessed for effectiveness annually (or upon Contract update)
Local Kentucky Quality Oversight and Resources	• **Kentucky Medicaid Plan CEO** (Jeb Duke) **and Kentucky Medical Director** (Dr. Galloway) lead and manage the ongoing QI process • Humana **Kentucky Medicaid Quality Improvement Director,** Ms. Summers, will lead and oversee day-to-day clinical and quality operations, direct performance improvement initiatives, review investigated cases as appropriate, participate on the Peer Review Committee, and co-chair the local Kentucky Medicaid QIC with the Medicaid Medical Director • **QMAC meetings** are held to engage Enrollees, actively-practicing network providers, Subcontractors, community agencies, and stakeholders in the QAPI program • **Local Provider Relations Team, including QIAs**, are equipped with provider-specific quality reports for face-to-face quality program/provider improvement opportunities • Quality committee structure and **program encompasses all levels of management and associates** (i.e., executive, middle, and front-line)

Table I.C.9-3: Components of Humana's QAPI Program

Component	Description
Annual Goals & Objectives	• **Annual QIWP** delineates goals and objectives based on the strengths and weaknesses identified in the previous year's annual evaluation report along with recommended strategies for improvement • **QIE** serves as our annual written evaluation of the previous year's QI program and its impact on Humana's PHM strategy • **Local QIC reporting to State agencies** on results, conclusions, recommendations, and implemented program and system changes
Evaluation of Clinical and Non-Clinical Initiatives	• **Annual PIPs** and integration of the results from PIPs for ongoing improvement and monitoring • **Integrated clinical platform** that supports the collection, tracking, analysis, and reporting of data and robust in-house quality data analytics capabilities enabling us to monitor, track, and improve the quality of care for our Enrollees • **Close partnerships with State agencies and External Quality Review Organizations (EQRO)** to implement and assess initiatives • Clinical leadership, in partnership with the Quality team, develop, implement, and monitor QI program initiatives to identify successes and failures
Data Analytic Capabilities	• **Integrated clinical platform, CGX**, that combines medical, BH, pharmacy, and social needs information to identify gaps in care and provide a 360-degree view of our Enrollees • Reporting and data analytic resources both in Kentucky and at the national level to support our HEDIS initiatives for Kentucky Medicaid **Performance Measurement Reporting Capabilities** • **HEDIS Reporting**: We report all NCQA HEDIS measures, **including BH measures**, across Medicaid, MA, and Commercial lines of business. Our Quality Systems and Integration (QSI) team oversees our HEDIS quality reporting, using a rules engine to support HEDIS reporting for operational and official applications. We conduct prospective measure analyses to support interim reporting in addition to the annual official submissions. • **Utilization Indicators**: We track and monitor utilization metrics to ensure our Enrollees are appropriately accessing care • **Other Clinical Indicators**: We measure additional clinical indicators such as the **CMS Child Core Set and internal care management measures**. We will partner with DMS to measure Agency for Healthcare Research and Quality (AHRQ) indicators and to develop new indicators based on the needs of the Kentucky Medicaid population **Other Quality Measurement Capabilities** • **CAHPS**: Humana conducts annual CAHPS surveys to assess Enrollee satisfaction for our Medicaid Enrollees. We will conduct the standard adult and child CAHPS surveys for our Kentucky Medicaid Enrollees to improve Enrollee satisfaction. • **Pulse Simulation Surveys**: We conduct a Medicaid Child Pulse Survey with 20 questions allowing Enrollees to respond to an expedited survey that enables us to maintain a "pulse" on Enrollee satisfaction between official CAHPS surveys

To ensure equitable care to our Enrollees, especially our priority populations, our QAPI program helps identify delivery of care and quality gaps, areas for improvement in condition management, and key drivers of disparities in health outcomes across our Medicaid population. CGX exists within CareHub, which links multiple systems and predictive models. CareHub collects, processes, tracks, and analyzes several data points that yield reporting

results specific to healthcare outcomes and performance metrics, including stratification of findings. We can **stratify our health outcomes based on age, race, ethnicity, language spoken, gender, and geographic region**.

f.	For each of the below quality measures, demonstrate how the Vendor will work to make improvements in Kentucky's Medicaid population. Include discussion of strategies and interventions specific to each measure, partners that will be necessary to achieve improvement, data analytics, and anticipated timeframes for success in achieving improvements. Describe potential challenges the Vendor anticipates, if any, and how those will be addressed. Provide examples of successes in other state Medicaid programs, and how that success will be leveraged in the Kentucky Medicaid market.

f.i.	Medication Adherence for Diabetes Medications

With this measure being primarily monitored and administered as a CMS Star Rating measure, Humana has extensive experience in maximizing the performance of this measure within our MA and Duals Demonstration populations within CMS's Medicare-Medicaid Financial Alignment Initiative. We will leverage this experience, as well as lessons learned, to implement effective interventions within our Kentucky Medicaid membership.

Strategies and Interventions: We conduct targeted outreach campaigns to engage identified Enrollees in our diabetes management program where our CCS team educates and assists Enrollees with proper diabetes management. We also execute high-touch outreach campaigns, sending targeted messages to those Enrollees with irregular medication habits, reminding them when it is time to refill their prescriptions and educating them on the importance of medication adherence. Humana also recognizes the impact depression can have on the physical health outcomes of our Enrollees with chronic conditions such as diabetes. We also ensure that we continuously screen and monitor all Enrollees participating in any of our Management of Chronic Conditions programs for depression and assist that Enrollee in managing their depression with pharmacotherapy or behavioral therapy when appropriate. Humana is also recommending this specific topic as the focus for one of the PIPs referenced in the following sub-question I.C.9.g.ii of this response.

Data Analytics: Our Pharmacy Analytics team maintains our internal **Medication Adherence Reporting Tool**, which allows us to monitor our performance in this measure throughout each year. We also use our clinical rules engine, Anvita, to mine claims and encounter data on an ongoing basis and identify diabetic Enrollees who are not consistently taking their diabetes medication. Our **analytics teams perform regression analyses** to measure the progress and success of these efforts, design studies for new test and learn activities, and monitor the impact of these medication adherence efforts on other diabetes-related HEDIS metrics (i.e., HbA1c control measures and blood pressure control).

Partners: **Provider partnerships** also play a key role in optimizing the medication adherence habits of our Enrollees. We collaborate with and share related metrics and medication management best practices with our providers on an ongoing basis. Providers also perform depression screening and depression management to help improve outcomes of these chronic conditions. Humana has also teamed with **WellDoc** to provide Enrollees with a **digital therapeutic application**, BlueStar, to control the blood sugar levels of persons with diabetes by providing real-time feedback on critical behaviors, such as diet and exercise, and by communicating lab results to the Enrollee and their clinical team. Humana's care team will connect directly with Enrollees through a two-way chat functionality. In a six-month trial with Medicaid Enrollees, BlueStar resulted in a **55% reduction in hospital admissions and a 16% drop in ED visits**.

Our Experience: We have implemented similar strategies to those mentioned above in our Illinois Duals Demonstration plan and have **exceeded the CMS target for Medication Adherence for Diabetes Medications**

three years in a row, while also improving the results at a rate of two point five (2.5) percentage points per year throughout that time. Downstream impact outcome metrics also show continuous improvement and are summarized in Table I.C.9-4 below.

Table I.C.9-4: Illinois Duals Demonstration Program – Diabetes-Related HEDIS Measures

Measure	2016	2017	2018
Comprehensive Diabetes Care – HbA1c Good Control (< 8.0%)	32.53	36.58	39.99
Comprehensive Diabetes Care – HbA1c Poor Control (inverse measure, lower is better)	61.83	56.52	52.07
Comprehensive Diabetes Care – Blood Pressure Control	35.29	43.28	43.80

Challenges, Mitigation Strategies, and Timeframe for Improvement: While we have demonstrated success in improving diabetes medication adherence, we do experience some challenges, such as the inaccuracy of Enrollee contact information and the historically lower contact and engagement rates among most Medicaid populations. However, through the ongoing evaluation and improvement of our strategies described above, we have been able to and will continue to overcome these challenges to the best of our abilities. Based on this experience, we anticipate at least three years will be needed to demonstrate similar sustained improvement in the Kentucky Medicaid population.

f.ii.	Tobacco Use and Help with Quitting Among Adolescents

Strategies and Interventions: We proactively work to identify tobacco users upon and throughout enrollment through our comprehensive risk assessment process. We provide educational materials to Enrollees and providers and offer Enrollees ages 12 and older access to programs such as the **Craving to Quit program**, a 21-day mindfulness-based wellness program based on a successful tobacco cessation curriculum developed and tested at Yale University. This evidence-based tobacco cessation program delivers treatment via mobile devices and the web and is proven to be twice as effective as other leading cessation therapies.

To effectively make improvements in curbing tobacco use, we must also address the rise in current trends such as e-cigarette use and vaping among teens. Studies show adolescents who use e-cigarettes are more likely to transition to smoking cigarettes[3]. In Kentucky, e-cigarette use among high school students (14.1%) is virtually equivalent to the number of teens smoking cigarettes (14.3%)[4]. Therefore, we will **provide pediatricians and pharmacies educational materials on the warning signs of smoking and e-cigarette use with adolescents** and techniques for early interventions with these Enrollees. According to the Centers for Disease Control and Prevention (CDC), effective educational programs for tobacco prevention could delay or prevent smoking onset in 20 to 40% of adolescents and are more effective when targeted at the ages of 11 to 15 years when adolescents are most likely to start smoking[5]. The CDC also reports school-based smoking cessation educational programs supported by community resources are more effective. We will modify traditional educational campaigns to include the potential dangers of e-cigarette use, with more **frequent outreaches to Enrollees ages 11 to 15 residing in rural areas**.

Data Analytics: Throughout the execution of these efforts, our **HEDIS and Clinical Analytics teams** monitor multiple outcome metrics through our HEDIS dashboards, including Advising Smokers to Quit and Discussing

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[3] https://www.ket.org/smoking/kentucky-youth-e-cigarettes-know/

[4] https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=KY

[5] https://www.cdc.gov/tobacco/data_statistics/sgr/2000/highlights/education/index.htm

Cessation Medications, to evaluate the effectiveness of these efforts on an ongoing basis, so that if necessary, we can adjust our strategy or create new interventions.

Partners: Humana will **offer to collaborate with Kentucky Department for Public Health (DPH) and the Kentucky Department of Education** as an advisor for future anti-tobacco school-based efforts.

Our Experience: The outcomes from studies of **previous Humana tobacco cessation programs have shown that up to one-third of enrolled participants quit smoking and tobacco use permanently**. These programs, combined with the aforementioned educational and awareness efforts, have resulted in improvement in related tobacco metrics in our 2016 to 2018 HEDIS rates for Medical Assistance with Smoking and Tobacco Use Cessation in the Kentucky Medicaid population. The results of its sub-measures are summarized in Table I.C.9-5 below.

Table I.C.9-5: Medical Assistance with Smoking and Tobacco Use Cessation HEDIS Performance for our Kentucky Medicaid Program

Measure	2016	2017	2018
Advising Smokers to Quit	69.54	73.05	73.63
Discussing Cessation Medications	40.74	47.87	48.72

Challenges, Mitigation Strategies, and Timeframe for Improvement: While we have demonstrated competency in smoking and tobacco use cessation, tobacco serves as a prominent cash crop and deeply rooted part of Kentucky culture, especially in rural areas where we see higher incidents of lung cancer[6] and chronic obstructive pulmonary disease (COPD)[7]. Kentucky also has some of the lowest-priced tobacco products in the country, despite cigarette tax increases per pack[8]. However, Humana will continue our attempts to overcome these obstacles by continuously evaluating and improving the aforementioned efforts and staying ahead of current smoking and tobacco trends (such as e-cigarettes) that pose new challenges. Past experience has shown us two to three years will be needed to sufficiently demonstrate sustained improvement in tobacco-related quality metrics.

f.iii.	Colorectal Cancer Screening

While this is historically a Medicare Stars measure, Humana's vast experience and success in improving this measure through our MA health plans, which cover more than four million lives nationally, with over 172,000 MA Enrollees in Kentucky, positions us well to address colorectal cancer screening among our Kentucky Medicaid Enrollees.

Strategies and Interventions: To improve outcomes associated with this measure, we **will leverage predictive models, analytics, provider and Enrollee education, and Enrollee messaging opportunities** to drive engagement and improvement in Enrollee health. We will identify Enrollees at high risk for colorectal cancer through our predictive models and HRAs, and we will conduct **provider education** on the importance of this preventive screening. For Enrollees requiring colorectal cancer screenings, we will:

- Conduct outreach and education campaigns

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[6] http://ci.uky.edu/kentuckyhealthnews/2017/01/25/eastern-kentucky-has-some-of-nations/

[7] http://www.arc.gov/images/appregion/fact_sheets/HealthDisparities2017/KYHealthDisparitiesKeyFindings8-17.pdf

[8] https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf

- Develop Enrollee care gap alerts for myhumana.com to notify Enrollees when they have missed their annual screening
- Implement a **pilot project to identify those with a high likelihood to accept colorectal cancer home screening test kits**, which continue to be a preferred method among our MA Enrollees. These home tests are especially beneficial to our Kentucky Enrollees as they help address the shortage of specialist physicians across the Commonwealth, especially in eastern Kentucky where, proportionately, there are 59% fewer specialty doctors than in the nation as a whole[9].

Data Analytics: To track outcomes for this measure in our Kentucky Medicaid population, our HEDIS and Clinical Analytics teams will develop custom analytics to monitor this measure for this specific population. These custom analytics will also measure the operational metrics such as contact and opt out rates for all outreach campaigns and test kit acceptance and completion rates in order to monitor the success of specific campaigns.

Partners: Humana also understands the importance of fostering a strong, **collaborative partnership with our provider network**, specifically our PCPs and pharmacists, when attempting to maximize our Enrollees' engagement in their preventive health. As previously mentioned, we provide our partnering physicians with an abundance of resources and information through routine meetings with our **QIAs**, where we share and discuss industry best practices and review needed preventive services and gaps in care for that individual provider's panel of Enrollees.

Our Experience: Our previous use of in-home test kits has shown immense success in closing these gaps. In 2018, Humana expanded our at-home testing program, distributing 204,000 colorectal cancer screening kits to Enrollees who did not show evidence of the screening. This was **a 67% increase in test kits distributed from 2017 and resulted in a 45% increase in sample returns**. To promote annual screening, as recommended by the American Cancer Society, Enrollees who received a kit in 2017 and returned a sample were automatically sent a test kit in 2018. This "automatic reorder" population had an exceptional **72% return rate**. We continue to work with our Enrollees to provide education and support for all types of colorectal cancer screening, but at-home test kits are a convenient way for Enrollees to get this important screening. We will develop our **home test kit pilot program for Kentucky Medicaid** to test the efficacy of this strategy within communities that may not have regular access to specialty providers, such as those in rural areas.

Challenges, Mitigation Strategies, and Timeframe for Improvement: As previously mentioned, the primary historical challenge with these types of campaigns in the Medicaid population has been the difficulty of contacting or locating these Enrollees in our attempts to engage them. As an additional effort to overcome this specific challenge, we intend **to incentivize our Enrollees to complete their HRA as part of our Go365 program**. We anticipate that the completion of this assessment will provide Humana with fully updated contact information for all communication channels, along with health information relevant to these types of efforts (e.g., family history), to use more effectively in future campaigns.

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[9] https://www.healthy-ky.org/newsroom/news-releases/article/112/appalachian-health-disparities-eastern-kentucky-has-more-mental-health-providers-but-fewer-of-most-other-docs-than-rest-of-commonwealth?

g.	Describe the Vendor's proposed approach to collaborating with the Department, other MCOs, and providers to ensure Performance Improvement Projects (PIPs) are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees, including the following:

g.i.	Lessons learned, challenges, and successes the Vendor has experienced while conducting PIPs, and how the Vendor will consider those experiences in collaboration with the Department on identified PIPs.

With more than 20 years of experience conducting PIPs for our Medicaid populations, Humana is well-versed in implementing and assessing PIPs in accordance with EQRO requirements, Humana priorities, and State-specified goals, as well as collecting and submitting performance measurement data to the Department and other required entities.

CHALLENGES

The Medicaid population presents unique challenges to take into consideration before, during, and after the PIP. The transient nature of this population presents considerable obstacles in maintaining valid contact information of our Enrollees. Our Medicaid Enrollees often do not have adequate transportation means and are unaware of plan benefits. Humana plans to reduce these barriers through a capped number of Non-Emergency Medical Transportation (NEMT) vouchers, incentivizing HRA completion, and greater outreach efforts via our CHWs and Enrollee education teams.

We have also learned that positive impact happens by implementing collaboration and engagement activities such as:

- Outreach to Enrollees with upcoming plan term dates to assist with eligibility redetermination to provide continuity of care
- Additional outreach to previous UTC Enrollees
- Inclusion of HRAs in the Enrollee Welcome Kit
- Follow up with Enrollees who experience missed transportation to identify potential barriers

LESSONS LEARNED AND SUCCESSES

Open Lines of Communication
We must make concerted efforts from the onset to ensure all key stakeholders are present during the initial phases of planning and all subsequent phases of the PIP. It is imperative to set clear expectations and delineation of duties (such as identifying responsible parties for generating data) at the onset so the PIP can proceed with effective oversight.

Understanding Enrollees' Barriers to Care

Understanding the barriers Enrollees face in accessing care is critical to formulating a successful intervention to improve outcomes. We have learned the value of a barrier analysis as a part of our PIP development, and this process leads to more successful interventions and outcomes. This is illustrated by our success with improving well-child visits for children ages 3 to 6 years (HEDIS W34 rate) in Kentucky (highlighted in Table I.C.9-6 below). In 2015, we found that our rate for W34 was below the NCQA 25th percentile and devised a systematic approach to identify barriers to these visits. We enacted evidence-based interventions based on the barrier analysis and CPGs and literature review and developed, implemented, and evaluated the effectiveness of an enhanced care coordination process.

Table I.C.9-6: Humana PIP Experience – Improving Well-Child Visits in the First Six Years of Life with Combined Interventions in Kentucky, 2016 to 2018

Well-child visits with a PCP are an important part of preventive services for children. Such visits include screenings that provide an opportunity to detect physical, developmental, and behavioral problems, as well as an opportunity for physicians to offer guidance and counseling to caregivers. Per 2016 HEDIS® rates, only 58.9% of Enrollees ages 3 to 6 received the recommended one or

Year	Well-Child Visits ages 3 to 6 years (W34) -Rate	Year-over-year (YOY) Variance
2016	58.9%	Baseline
2017	61.3%	2.4%
2018	65.2%	3.9%

more well-child visit(s). The lack of care indicated by these rates was due to a combination of barriers including a lack of knowledge by parents/ guardians (hereafter referred to as caregivers) of the importance of regular well-child visits, difficulties they face accessing PCP care for their child, PCP's lack of adherence to best practices, as well as others. Conversely, the rates also highlighted an opportunity for us to assist and engage Enrollees and providers in overcoming these barriers so Enrollees can receive the care they need and to which they are entitled. Associated interventions included: Provider education via newsletters; Enrollee education via Enrollee newsletters, booklets, and calendars; team-based outreach calls and community events for Enrollees and their caregivers; and enhanced care management. These interventions yielded a 6.3% increase in the W34 rate over the baseline.

The project provided valuable insight into barriers Enrollees face and that hinder their ability to obtain appropriate preventative health screenings for this population. Among the barriers encountered were Enrollee transportation issues, Enrollees' inability to make numerous appointments for multiple children, and our inability to successfully reach some Enrollees due to frequent cell phone number changes. However, our clinical approach in knowing and understanding each Enrollee from a holistic point of view has facilitated better interactions with Enrollees regarding needed preventive care and coordination of care.

Frequent Monitoring of Metrics
Well-developed PIPs should include a variety of lead and lag metrics, which can present data collection challenges. We have learned the value of the PDSA cycle and frequent and ongoing metric measurement throughout the PIP lifecycle. This increased monitoring of metrics enables us to determine which aspects of the PIP are effective and which are not so that we may redirect our planning efforts. This is best demonstrated in our dental PIP (highlighted in Table I.C.9-7 below) where we realized our mailing campaign efforts were ineffective, so we transitioned to one-on-one Enrollee direct calls and dispatched our QIAs to provide gap reports to our provider community.

Table I.C.9-7: Humana PIP Experience – Promoting Oral Health in Children

In partnership with the State of Florida, Humana implemented a PIP to increase the number of Medicaid Enrollees receiving an annual dental visit. Our health promotion and education initiatives in Florida to increase the number of Enrollees receiving preventive

Year	Annual Dental Visit (Total) Rate	YOY Variance
2015	46.10%	Baseline
2016	48.54%	2.45%
2017	51.93%	3.38%

dental care have yielded statistically significant outcomes and improvements. We distributed our **Medicaid HEDIS, CAHPS Guide & Checklist** to providers, educating them on the importance of preventive dental services and the periodicity schedule associated with those services. Our **QIAs** also visited pediatrician offices to deliver

Table I.C.9-7: Humana PIP Experience – Promoting Oral Health in Children

the **Provider Educational Pamphlet** for dental services and worked with PCPs on how to educate Enrollees on covered dental services. We delivered the **Monthly Action List and Report Card** to PCPs and our dental Subcontractor to help identify care gaps. Finally, our **Dental Call Campaign** targeted outbound calls to Enrollees with open dental care gaps. These interventions yielded a statistically significant increase in Enrollees receiving preventive dental care.

Strong PIP Governing Structure

We evaluate each QI initiative within the larger PIP to identify lessons learned. These are formally reported during our QIC meetings where we strategize and identify ways to improve processes and define parameters for future initiatives. In conjunction with our QIC, our **QOCA team**, which oversees PIP development for all of our Medicaid markets, uses past experience and knowledge gained to develop best practice guidelines. Our **Quality Initiative Governance Committee** reviews HEDIS performance data monthly (or more frequently if needed) in our Kentucky Medicaid market to inform future areas for PIPs.

COLLABORATION WITH THE DEPARTMENT

We look forward to partnering with the Department to establish an approach to Department-Managed Care Organization (MCO) collaboration that not only ensures PIPs are effective but also includes the sharing of best practices and lessons learned to meaningfully improve the Department's priority areas. In addition to our participation in quarterly quality meetings with the Department, **we propose hosting collaborative meetings to include DPH, DMS, and other MCOs to work on priority areas and projects**. In these meetings, we will look to design and develop innovative solutions regarding shared barriers to quality outcomes such as unable-to-contact (UTC) Enrollees, Enrollees transitioning between MCOs, and Enrollees' access to transportation. We will use our lessons learned, robust data analytics capabilities, and market quality teams, including our Kentucky QIC, to support our collaborative efforts with the Department and to ensure operational and clinical success across our QI initiatives within each PIP.

g.ii.	Recommended focus areas, including those for regional collaborative PIPs, for the first two years of the Contract resulting from this RFP and rationale for these focus areas.

Methodology

To form our recommended focus areas, we referenced IPRO's draft 2019 External Quality Review Technical Report to assess statewide performance across all MCOs. We used Quality Compass HEDIS data from 2016 to 2018 to compare Kentucky Medicaid incumbent performance across measures. We also used research from credible sources such as the CDC and DPH's "State Health Improvement Plan 2017-2022" to identify areas of improvement.

Recommended PIP 1: Annual Wellness Visits for Both Children and Adults (Humana)

Rationale: The Commonwealth is underperforming with respect to its well-child visits both in the first 15 months of life and in 3 to 6 years of life as well as its adult preventive measures (such as cervical cancer screenings and flu vaccinations). Engaging in preventive care through PCP visits leads to **improved health outcomes, empowers Enrollees to engage in their healthcare, and lowers costs**. We propose a PIP to (1) increase well-child visits both in the first 15 months of life and at ages 3 to 6 and (2) increase annual wellness visits for adults. We recognize aspects of our Kentucky population present challenges, such as access to care, particularly those in Appalachia, where the supply of PCPs is 26% lower than the national average[10]. We remain cognizant of these challenges in our proposed interventions.

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[10] http://www.arc.gov/images/appregion/fact_sheets/HealthDisparities2017/KYHealthDisparitiesKeyFindings8-17.pdf

Proposed Interventions:
- We will pilot a **feet-on-the-street campaign** where our locally based CHWs in Louisville will conduct in-person reminders for wellness visits for Enrollees stratified as high risk and emerging high risk and who have not had a PCP visit in the previous year; our CHWs will assist with scheduling visits during these in-person reminders and ensure transportation is scheduled, if needed
- Our Quality team will do targeted outreach for adult Enrollees and children behind their periodicity schedules
- Screen for unmet social needs via our HRA to identify unmet social needs that prevent Enrollees from receiving their annual wellness exams (or filling important/maintenance prescriptions) so we can connect Enrollees with proper resources
- Implement large-scale text messaging and mailing campaigns as reminders for annual wellness visit
- Use our VBP model to incentivize PCP outreach
- Increase PCP education and awareness of Enrollee benefits including transportation
- Raise awareness of our NEMT supplemental benefit among our population
- Incentivize Enrollees for annual wellness visits and well-child visits via Go365

Proposed Metrics: We will measure performance with the following metrics:
- Adults' Access to Preventive/Ambulatory Health Services, Children and Adolescents' Access to Primary Care Practitioners, Well-Child Visits, and Adolescent Well Care Visits
- Humana will work with the Department, Commonwealth, PCPs, and quality teams to identify appropriate lead and lag measures

Recommended PIP 2: Improve Access to Cancer Screenings (Collaborative)
Rationale: Kentucky suffers from the highest cancer rates in the nation. Experts say Kentuckians remain unaware of screening recommendations and have low health literacy[11]. Given the low rates across the Commonwealth for screenings, Humana proposes a collaborative PIP with other MCOs to provide increased and targeted education to providers and Enrollees to improve access to cancer screening. A collaborative approach will foster improved referral practices and thus more preventive screenings among the entire Kentucky Medicaid population, resulting in improved health outcomes and lower costs across the Commonwealth.

Proposed Interventions:
- Educate PCPs on proper specialist referral practice
- Keep PCPs updated on plan benefits and Enrollee gaps in care
- Targeted texting and mailings to educate Enrollees on screening(s)
- Targeted outreach for populations with historic health inequities (e.g., African American women are more likely to receive a diagnoses at a later stage, have delayed treatment[12], and are 42% more likely die from breast cancer; Eastern Kentucky suffers from disproportionately high cancer rates[13])
- Incent the following behaviors: Recommended mammograms for women ages 50 to 64 and recommended cervical cancer screenings for women ages 24 to 64
- Use our supplemental Social Needs Assessment to identify unmet social needs that prevent Enrollees from accessing recommended preventive screenings and connect Enrollees with proper resources
- Utilize our VBP model to incentivize PCP outreach for cancer screenings

Proposed Metrics: We will measure performance with the following metrics:
- Breast Cancer Screening, Cervical Cancer Screening, and Colorectal Cancer Screening

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[11] https://www.cdc.gov/nchs/pressroom/states/kentucky/kentucky.htm
[12] https://www.fightcancer.org/sites/default/files/FINAL%20-%20Disparities%20AABreastCancer%2002.14.17%20.pdf
[13] http://ci.uky.edu/kentuckyhealthnews/2017/01/25/eastern-kentucky-has-some-of-nations/

- Humana will work with the Department, Commonwealth, other MCOs, PCPs, and quality teams to identify appropriate lead and lag measures

Recommended PIP 3: Opioid Use (Collaborative)

Rationale: The opioid epidemic in Kentucky has had devastating effects. NAS is on the rise[14], 54 counties (almost half) in Kentucky are vulnerable to significant increases in hepatitis infection or an HIV outbreak due to injectable drug use[15], and an increasing number children are being displaced from their families[16]. In 2017, there were 1,160 reported opioid-related deaths in Kentucky, almost double the national average, according to the National Institute on Drug Abuse[17].

> Between 2016 and 2018, use of Medication-assisted Treatment (MAT) among Humana Kentucky Medicaid Enrollees **increased by 111%**, while the number of opioid prescriptions **decreased by 19%**.

Medicaid Enrollees accounted for more than half of opioid overdose ED visits[18]. Compounding the issue are prescribing rates; Kentucky is one of the top 10 states with the highest opioid prescribing rates, with Commonwealth providers writing 86.8 opioid prescriptions for every 100 persons in 2017[19].

To effectively address the opioid epidemic, a coordinated effort among all MCOs is necessary. Therefore, Humana recommends a collaborative PIP to decrease opioid use.

Proposed Interventions:
- Leverage our Opioid Predictive Model that identifies Enrollees at risk for diagnosed opioid abuse by using pre-diagnosis characteristics and behaviors of diagnosed Enrollees 30 to 210 days prior to diagnosis
- Encourage Enrollees to use our value-added services offering, myStrength (an evidence-based and clinically-reviewed digital, integrated platform that provides guided experience to users for BH conditions), and to enroll in myStrength's Substance Use program, which builds awareness of usage patterns alongside in-depth cognitive behavioral therapy (CBT)-based relapse prevention for supportive recovery experience
- Analyze and report on provider prescribing patterns
- Administer provider call campaign to encourage prescription of naloxone as a rescue medication along with opioid prescription
- Apply point-of-sale hard edits to limit opioid day supply, limit opioid dose to less than 100 morphine milligram equivalents (MME), or restrict use of multiple providers/pharmacies without a prior authorization (PA)
- Apply point-of-sale soft edits to request a pharmacist review when an Enrollee has an overlap of opioid, benzodiazepine, and muscle relaxant medications or is filling a prescription for an opioid dose greater than 90 MME

Proposed Metrics: We will measure performance with the following metrics:
- Use of Opioids at High Dosage and Use of Opioids from Multiple Providers
- Humana will work with the Department, Commonwealth, other MCOs, PCPs, and quality teams to identify appropriate lead and lag measures

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[14] https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary

[15] https://www.cdc.gov/pwid/vulnerable-counties-data.html

[16] https://kentucky.kvc.org/2017/02/20/the-opioid-epidemics-effect-on-kentucky-children-how-you-can-help/

[17] https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary

[18] https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf

[19] https://www.cdc.gov/drugoverdose/maps/rxstate2017.html

Recommended PIP 4: Adherence to Antidepressant Medication for Individuals with Diabetes (Humana)

Rationale: Kentucky has the fifth highest diabetes mortality rate in the nation[20], with 15.3% of the adult population having diabetes[21], and it is the seventh leading cause of death in Kentucky[22]. With more than one-third of the population pre-diabetic and direct medical expenses for diabetes diagnoses totaling $3.6 billion in 2017[23], DPH has declared diabetes as a key public health concern.

According to the CDC, individuals with diabetes are twice as likely to develop depression[24]. Research continues to show the maintenance of one's mental health is imperative for diabetes management[25] and that poor adherence to antidepressant medication can exacerbate depression among these individuals[26]. Mental illness often reduces the likelihood of proper diabetic treatment[27]. Adult Kentuckians feel mentally unhealthy more than the national average (about 25% above the national average for adults in eastern Kentucky and 10% above the national average for Kentucky adults outside of Appalachia[28]).

> In 2018, we saw **a 19.6% increase in diabetic Enrollee compliance of blood pressure control <140/90** and a **15% increase in diabetic Enrollees receiving an annual eye exam** among our Kentucky Medicaid population.

Humana sees opportunity to increase antidepressant medication adherence for individuals with diabetes and therefore recommends a PIP to increase antidepressant medication management for individuals with diabetes. We will leverage **our integrated clinical delivery model to provide Enrollees integrated care** and our experience in antidepressant medication management.

Proposed Interventions:
- Incentive for recommended diabetic screenings for Enrollees 18 years of age and older via Go365
- Encourage Enrollees to use our value-added services offering, myStrength, and enroll in myStrength's Depression program, an interactive mood management program that provides CBT in a step-by-step approach
- Include depression screening into annual assessments of Enrollees in care management
- Implement periodic follow-up depression screenings during enrollment in any of our Chronic Condition Management Programs
- Use our supplemental Social Needs Assessment to identify unmet social needs that could negatively impact medication adherence and diabetes management (e.g., food insecurity could limit Enrollee access to nourishing foods, housing insecurity could impair Enrollees from being able to refrigerate certain medications) and connect Enrollees with proper resources and dietary education
- Use data analytics to determine downstream impact on other physical and BH conditions
- Make medication adherence a priority area for our CMs
- Create targeted education campaign for those identified as at risk

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[20] https://www.cdc.gov/nchs/pressroom/states/kentucky/kentucky.htm

[21] http://www.diabetes.org/assets/pdfs/advocacy/state-fact-sheets/kentucky-state-fact-sheet.pdf

[22] https://www.cdc.gov/nchs/pressroom/states/kentucky/kentucky.htm

[23] http://www.diabetes.org/assets/pdfs/advocacy/state-fact-sheets/kentucky-state-fact-sheet.pdf

[24] https://store.samhsa.gov/system/files/sma13-4780.pdf

[25] http://diabetes.org/living-with-diabetes/complications/mental-health/

[26] https://store.samhsa.gov/system/files/sma13-4780.pdf

[27] https://store.samhsa.gov/system/files/sma13-4780.pdf

[28] https://www.healthy-ky.org/newsroom/news-releases/article/112/appalachian-health-disparities-eastern-kentucky-has-more-mental-health-providers-but-fewer-of-most-other-docs-than-rest-of-commonwealth?

Proposed Metrics: We will measure performance with the following metrics:
- Antidepressant Medication Management and Comprehensive Diabetes Care measures (for this specific sub-population)
- Humana will work with the Department, Commonwealth, PCPs, and quality teams to identify appropriate lead and lag measures

g.iii.	Methods for monitoring an ongoing evaluation of progress and effectiveness.

As outlined in sub-question I.C.9.a.v, Humana employs the PDSA data-driven improvement cycle and the use of rapid-cycle improvement methods to develop, maintain, monitor, and adjust clinical and non-clinical initiatives. PIPs are managed and monitored via **monthly work groups**, and all PIP progress is overseen by the Quality Initiative Governance Committee during monthly reviews. We measure and monitor year-to-date metrics on a monthly basis to inspect the effectiveness of the interventions, allowing us to quickly identify opportunities for adjustment and improvement and correct them in a timely manner. Formal measurement and re-measurement is completed on an annual basis starting from the time of the initial baseline data measurement. We monitor more than just the progress of the targeted metric; we also monitor the following indicators and outcomes:
- Any relevant established sub-measures (i.e., HEDIS age bands)
- Custom breakouts of targeted sub-populations
  - Race/ethnicity
  - Language
  - Geographic region
  - Gender
  - Age
  - Eligibility type (Temporary Assistance for Needy Families, Supplemental Security Income, dual eligible, etc.)
- Downstream impact metrics (i.e., improving access to metrics' downstream effect of disease management metrics)
- Operational Metrics
  - Call reach rates
  - Returned mail rate
  - IVR transfers
  - Messaging opt-out rates
- Any relevant survey data
  - CAHPS/HOS
  - Custom Enrollee surveys
  - Provider surveys

During the lifecycle of the PIP, we deploy **PIP subcommittees** to review trends, conduct root cause analyses to identify underlying issues, implement QI initiatives, and provide progress reports. We regularly review this progress at **QIC meetings** to identify barriers, opportunities, and needed improvements and changes. This cross-functional forum helps develop solutions that cannot be resolved by our PIP subcommittees or taskforces alone.

Lastly, our **Quality Initiative Governance Committee meets monthly** (or more frequently if needed) to review our performance across all of our State Medicaid programs, share best practices and lessons learned, and guide the creation of PIPs and initiatives in other markets.

> **Monitoring PIP Ongoing Progress and Effectiveness**
>
> Our Florida QIC meetings discussed ongoing barriers to our PIP in improving the timeliness of prenatal care and well-child visits in the first 15 months of life. It was revealed that (1) some providers saw little importance of notifying the plan of timely OB/GYN referrals, and (2) Enrollees had a knowledge deficit related to the importance of receiving prenatal care. The QIC recommended improvement strategies, and as a result, Humana achieved a 73.97% 2018 HEDIS W15–six or more visits rate, exceeding the State of Florida's 50th percentile target goal of 67.91%.

h.	Provide a description of opportunities the Vendor has identified to collaborate with the Department for Public Health to support improvement in public health outcomes. Where does the Vendor anticipate that collaborating on initiatives would have the most impact in addressing quality care and outcomes for Medicaid Enrollees? Explain the Vendor's rationale.

Humana is motivated and prepared to collaborate with the Department on initiatives that bring sustained improvements to the quality of care for Kentucky Medicaid Enrollees. We will leverage our experience gained from serving Medicaid Enrollees in the Commonwealth since 2013 (experience that is enhanced by our vast experience serving Medicaid and Medicare Enrollees in other states) to devise impactful and timely interventions for areas that align with Kentucky's Medicaid Managed Care Quality Strategy[29] and are outlined below.

BH and SUD
Humana's approach to integrated care is built on the understanding that BH and social needs are as essential to the well-being of our Enrollee population as is physical health. Today, more than one-quarter of our Kentucky Medicaid Enrollees have a BH condition, including 10% (14,289) with a serious mental illness (SMI) diagnosis and 13% (17,952) with an SUD diagnosis. We are committed to working with the Commonwealth and DPH to address the BH needs of our Enrollees through a fully integrated model of care and by leveraging internally built systems, coordinated staffing plans, and aligned processes – as well as leading innovative community and provider partnerships that leverage the expertise of Kentucky's BH infrastructure, which ultimately ensure our Enrollees receive high-quality, evidence-based services, regardless of diagnosis or circumstance.

Chronic Disease Management and Priority Conditions
Humana provides targeted chronic condition management interventions. These interventions are Enrollee-centric and in-line with Humana's person-centered model of care focused on behavior change and self-management. We will work with DPH and the Commonwealth to implement program supports for:

- Acquired and congenital heart failure
- Attention deficit hyperactivity disorder (ADHD)
- Asthma and COPD
- Depression/postpartum depression
- Diabetes
- Hepatitis C treatment
- HIV/AIDS
- Hypertension
- Post-traumatic Stress Disorder and Adverse Childhood Experiences (ACE)
- Serious Emotion Disturbance (SED)
- Sickle Cell Disease
- SUD, including opioid disorder

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[29] COMMONWEALTH of KENTUCKY Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services, July 2019.

Wellness and Prevention

- Obesity: Obesity rates in Kentucky continue to rise and affect all ages: 34% of adults[30] and 17% of children and adolescents ages 2 to 19 are obese. Kentucky has the fifth highest rate of obesity in the nation[31], and by 2030, the obesity rate could surpass 60%[32]. Obesity increases the risk of developing chronic co-morbid conditions that are highly prevalent among Kentuckians, such as diabetes, stroke, heart disease, asthma, and cancer[33]. With heart disease as the leading cause of death in Kentucky and stroke the fifth[34], addressing and solving the obesity crisis is critical. IPRO's draft 2019 External Quality Review Technical Report revealed the majority of health plans perform below the NCQA national Medicaid 25th percentile with respect to counseling for nutrition and counseling for physical activity HEDIS measures.

- Hepatitis A: According to DPH, Kentucky is still in the midst of its Hepatitis A outbreak. Since August 2017, the DPH has identified more than 4,000 cases of Hepatitis A[35]. The urgency of this outbreak necessitated collaboration among all Kentucky MCOs. Because of our vaccination policy, we were well-positioned to assume a leadership role in this collaborative effort.

> At the onset of the 2017 Hepatitis A outbreak, Humana was the only plan that did not require PAs for the Hepatitis A vaccine delivered at a pharmacy, removing a barrier for our Enrollees to receive timely vaccinations.

- Prescribing Antibiotics to Treat Upper Respiratory Infections and Bronchitis: Kentucky is underperforming with respect to the Appropriate Treatment for Children with Upper Respiratory Infection and Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis HEDIS measures. According to the IPRO's draft 2019 External Quality Review Technical Report, all Kentucky Medicaid MCOs performed below the national Medicaid 25th percentile. We see an opportunity to conduct provider education outreach with a focus on appropriate prescribing guidelines. We will leverage our experience in improving the Appropriate Testing for Children with Pharyngitis HEDIS measure, where in years 2017 and 2018 we were at or above the NCQA national Medicaid 50th percentile, according to IPRO's draft 2019 External Quality Review Technical Report.

Health Transformation and Value-based Care

Value-based care is embedded throughout Humana's operations. We believe in rewarding strong performance regardless of practice size or provider type. We have found that value-based care leads to improved health outcomes. We will work with the Commonwealth and DPH to explore strategies where value-based care arrangements help improve the health and quality of care for Kentuckians.

Special populations

Humana has more than 30 years of experience serving special populations, such as mothers and babies, children within the foster care system, and justice-involved adults with SUD or SMI, within our Medicaid Managed Care (MMC) programs. We will bring best practices, lessons learned, and innovative models that have been developed and piloted across the country to partner with DPH to ensure the best possible care to our Kentucky Medicaid Enrollees.

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[30] https://www.cdc.gov/obesity/data/prevalence-maps.html

[31] https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/obesity.aspx

[32] http://louisville.edu/doc/disease-information/diabetes-in-kentucky

[33] https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf

[34] https://www.cdc.gov/nchs/pressroom/states/kentucky/kentucky.htm

[35] https://chfs.ky.gov/agencies/dph/Pages/default.aspx

NEED FOR COLLABORATION

Humana understands we are not alone in solving the health needs of our Medicaid Enrollees. Nowhere is this more evident than in our population health strategy, where we proactively create partnerships with CBOs, non-profit organizations, government, and business leaders, as well as physicians, clinicians, and hospital systems to improve the health and well-being of our Enrollees.

Humana has experience collaborating with other Medicaid MCOs to improve health outcomes for the populations we serve. In other markets we have led symposia to bring MCOs together, and we collaborated with the other Kentucky MCOs throughout the Hepatitis A outbreak. We are ready and willing to **work with the Commonwealth of Kentucky to facilitate a quarterly collaboration** meeting involving DPH, DMS, sister agencies, and other health plans to explore how managed care can support the attainment of Kentucky's quality and health outcome goals. Within the proposed quarterly meetings, Humana recommends prioritizing collaborative discussions around improvement strategy for the following areas of opportunity regarding the overall health of Kentuckians:

- Perinatal care and birth outcomes, specifically within high-risk pregnancies
- Enrollees with Special Health Care Needs (ESHCN)
- The opioid epidemic and general substance abuse
- Obesity and related illnesses (heart disease, hypertension, diabetes, etc.)
- Tobacco use and vaping cessation, particularly amongst youth
- Improving preventative care access in rural communities

Humana is an ideal partner in leading this meeting given our experience convening similar meetings in our Florida Medicaid program (highlighted below). We will leverage our experience convening symposia to share best practices, lessons learned, and barriers to brainstorm on Enrollee opportunities and common ways to monitor and measure outcomes. Our recommendations for top priorities for discussion would be: continuity of care for Enrollees changing between MCOs, collaborative approach to addressing opioid abuse, and improving maternal and child health outcomes in the Commonwealth.

Collaboration Spotlight:

In March 2019, **Humana convened a symposium of five Medicaid health plans to discuss strategies for improving birth outcomes** among Tampa's Medicaid population. Humana brought together these payers with the recognition that **population health issues like poor birth outcomes cannot be tackled by a single MCO**. Rather, such problems require payers, providers, communities, and individual Enrollees to work together to develop solutions. During the symposium, participants reviewed the various factors that may contribute to adverse birth outcomes and identified both downstream (i.e., clinical and behavioral) and upstream (i.e., non-clinical) solutions. At the conclusion of the meeting, participants identified next steps, assigned owners for each action item, and designated points of contact for continued collaboration.

I.	Describe the Vendor's approach to monitoring and evaluating progress in improving the quality of health care and outcomes on an ongoing basis. Describe the following:

Humana's experience in monitoring and evaluating progress in quality is supported by strong capabilities and resources. We use measures defined by HEDIS, National Quality Forum (NQF), AHRQ, CMS, 3M PPE Tools, and professional medical societies to assess our performance and identify areas of opportunity. We employ several quality and clinical analytics teams to regularly monitor our performance. Our robust reporting tools (such as those housed in CareHub as outlined in sub-question I.C.9.a.iv) support our PDSA data-driven improvement cycle that includes rapid-cycle improvement methods and use of lead and lag measures.

i.e.	How the Vendor will use data to inform and prioritize initiatives to address Enrollee needs.

To support our data-driven QI program, Humana frequently measures, monitors, and evaluates our performance against State-specified benchmarks, NCQA benchmarks, and operational and lead/lag metrics associated with quality initiatives in order to conduct **ongoing oversight and improvement of physical health, BH, and support services**. Below we summarize our HEDIS and additional reporting capabilities that support and prioritize our data-driven initiatives.

Humana uses our QAPI program to improve health outcomes and in doing so is focused on the distribution of those outcomes across key sub-populations. Our QAPI program helps identify delivery of care and quality gaps, areas for improvement in chronic condition management, and key drivers of disparities in health outcomes among our Enrollees. Our **IT infrastructure and data analytic capabilities** provide the foundation for identifying care gaps and quality of care issues. Humana achieves systematic measurement and assessment of performance using multiple data systems. We evaluate these systems annually to verify that we have adequate resources to meet the needs of the program. Our integrated system resources enable focus on overall health of our Enrollees while closing care gaps and improving quality care outcomes. Using our clinical health platform, CareHub, we monitor care gaps at the Enrollee and population levels, targeting interventions based on identified conditions, both acute and chronic.

DATA SOURCES AND MEASUREMENT

Our **HEDIS dashboard** serves as our internal Medicaid HEDIS reporting tool. **Updated monthly**, it aggregates Medicaid Enrollee data, provides data at an Enrollee-level detail, and helps define populations for pilot campaigns. This dashboard includes all HEDIS measures and sub-measures on which we report and trend performance (including a prior three-month trend and our performance relative to the 50th and 75th percentile bands) to monitor and assess progress on any measure. The dashboard can be filtered by market, region, demographics, etc. to identify specific performance disparities. Our HEDIS dashboard feeds our **gap-in-care reporting** capabilities, which include notifications via our integrated clinical platform, CGX, our Enrollee Services platform, and reports to providers with outstanding care gaps for Humana Enrollees. **Anvita** is Humana's internally managed HEDIS rules engine that allows us to **generate care gap reporting on a daily basis**. This enables us to to source Enrollee alerts, predictive models, and provider reporting on open care gaps and needed preventive services, which supports our rapid-cycle QI activities. We also draw upon a comprehensive set of data sources to inform any opportunities for improvement and associated initiatives. Table I.C.9-8 below contains the quality data sources we use to inform and prioritize initiatives.

Table I.C.9-8: Quality Data Sources Used to Inform and Prioritize Initiatives

Report	Description
Inpatient Census Report	Daily detailed account of acute and sub-acute inpatient facility admission cases
3M PPE Report	Identifies admissions, readmissions, facility-based complications, ED visits, and ancillary services that likely could have been prevented
Inpatient Clinical Dashboard	Weekly reporting of key operational metrics, such as time from receipt of authorization to nurse receipt, time for clinical decisions, discharge plan documentation, Enrollees contacted for post-discharge follow up, clinical program reach, and engagement rate

Table I.C.9-8: Quality Data Sources Used to Inform and Prioritize Initiatives

Report	Description
EIR	Monthly reporting of key utilization metrics such as: • Admits/1,000 by utilization type (Acute, Skilled Nursing Facility, Rehab, Long Term Acute Care Hospital) • Inpatient days/1,000 • Length of service by type • ED visits/1,000 Dashboard format allows user drilldown for analysis by demographics such as geographic region, plan type, and age of user
High Utilizer Report	Monthly report allowing us to drill down into individual Enrollees with high utilization by service type, e.g., ED, inpatient care, etc.
Provider Utilization Profiling	Quarterly provider-level report of claims and encounter data to analyze under and overutilization and to provide peer-to-peer analysis
Predictive Model Reporting	• **Medicaid Severity Score Predictive Model**, updated monthly • **Inpatient and Readmission Predictive Model**, updated daily from admission to discharge, integrated into our clinical platform, CGX, to trigger referrals for clinical programs • **ED Predictive Model** scores available by report each month and are integrated into CGX • **Opioid Predictive Model** to enhance efforts to identify high-risk Enrollees
Readmissions by Provider	Monthly tracking of 14- and 30-day readmission rate for acute admissions and physician visit within 14 and 30 days of discharge date
High-cost Prescription Report	Report identifies Enrollees who have 10 or more unique drugs that average more than $250 per prescription

PERFORMANCE ANALYSIS

Annually, as a part of our **QIE**, we develop our **QIWP** that outlines our goals and objectives for the upcoming year. To ensure we are tracking to our goals, we review a wide variety of data and metrics monthly at our QIC meeting to identify any trends or areas that may need further investigation. As a part of our root cause analysis processes, the **Humana Medicaid Trend Analytics** team identifies and analyzes utilization that may have an impact on quality of care. The Medicaid trend process occurs monthly and encompasses leadership from network, clinical, financial, operational, and actuarial teams who meet monthly to review and evaluate trend results across all Medicaid lines of business, which promotes the sharing of best practices to address identified issues across our Medicaid plans. The team analyzes data and finds opportunities to lower inappropriate utilization and improve quality of care through:
- Significant changes or expansion of current initiatives
- Creation of new initiatives
- Robust dialogue and cross-functional collaboration
- Evaluation of year-over-year utilization metrics to identify longitudinal trends

Business leads present execution and status updates of the operationalized initiatives in these meetings. Additional semi-annual trend summits occur where we brainstorm and discuss potential future initiatives.
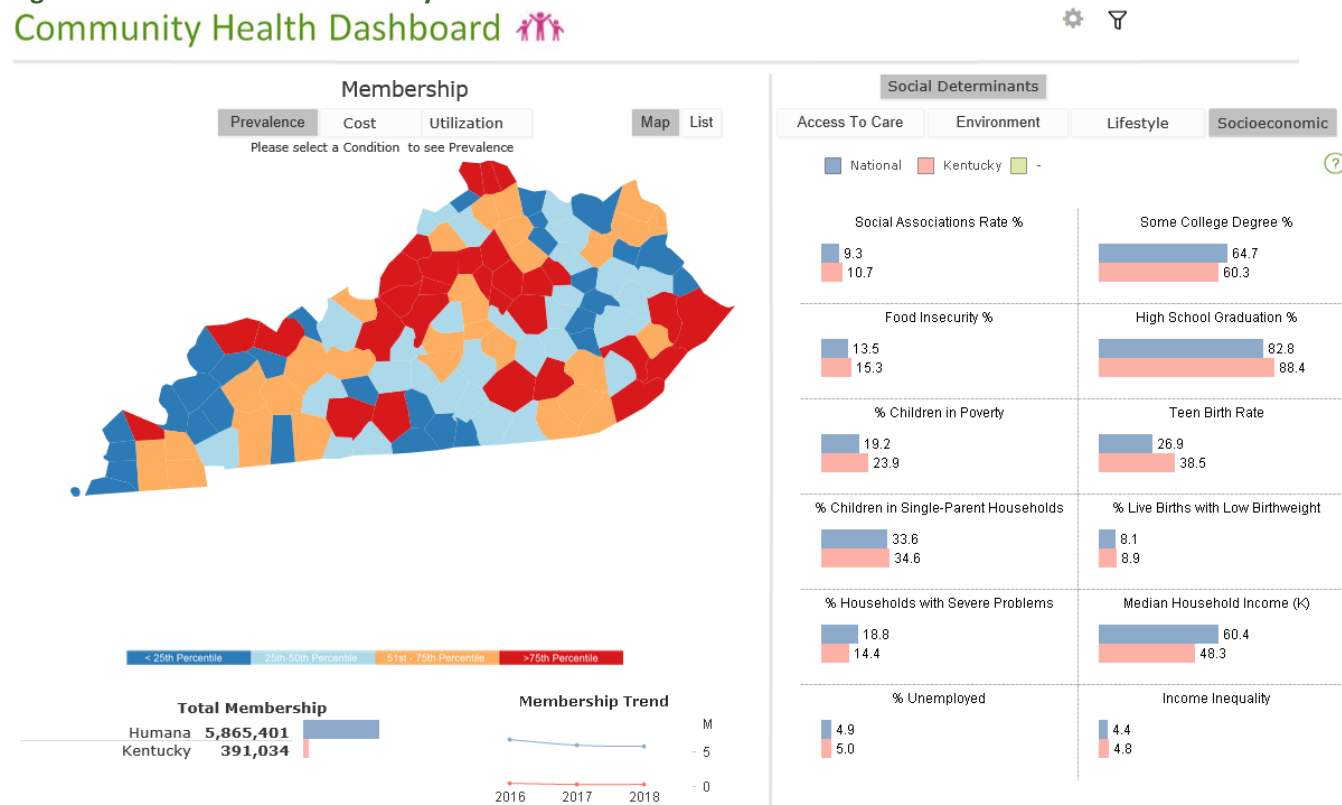
Trend Analytics team: A critical part of our Medicaid Trend team, Humana's Trend Analytics team is responsible for high-level analyses and forecasts of Medicaid trends. Key responsibilities of this group include:

- Monitoring early indicators and presenting to key stakeholders monthly
- Identifying emerging trends in data and assess for potential improvement opportunities and presenting to the Trend committee
- Monitoring and extrapolating from PPE analytics to identify and prioritize opportunities for improvement

ROOT CAUSE ANALYSIS

Humana deploys a rapid-cycle improvement process through which we are able to quickly identify opportunities for QI and devise targeted interventions informed by data. Once we have identified gaps in care delivery, quality of care issues, and/or disparities in health outcomes, we conduct **root cause analyses** to identify why an issue occurred. As a part of our root cause analysis process, we analyze trends and data based on geographic and demographic data, stratifying outcomes by race, ethnicity, language spoken, gender, and zip code. We use our **Community Health Dashboard** (Figure I.C.9-5) to map care needs and related indicators among the populations we serve. The application provides a better understanding of a community, its comorbidities, utilization metrics, and socioeconomic environments in a visually rich and interactive web-based platform. This informs our improvement intervention and tailors interventions to address priority populations and Enrollees experiencing health disparities.

Figure I.C.9-5: Humana Community Health Dashboard

INITIATIVE DESIGN & EXECUTION

Our **Medicaid Quality Initiative Governance Committee** provides oversight of all Medicaid QI and performance goals/benchmarks, strategy, and performance improvement efforts across our organization. This Committee infuses best practices across our Medicaid markets and throughout the organization through a consistent approach to QI efforts, interventions, and initiatives – greatly reaffirming Humana's culture of CQI – and secures

the requisite corporate resources and support to effectuate consistent monitoring and measurement of ongoing analyses. Given this Committee's responsibility to QI governance, the Quality Initiative Governance Committee hears and approves proof of concept for all new and renewing QI initiatives, process improvement projects, State-mandated PIPs, quality improvement projects (QIPs), and pilot studies that impact Medicaid. Our Quality Initiative Governance Committee utilizes data and insights gleaned from root causes analyses to inform thoughtful initiatives with the potential to transform Enrollee and population level health outcomes and the ability to be rapidly deployed.

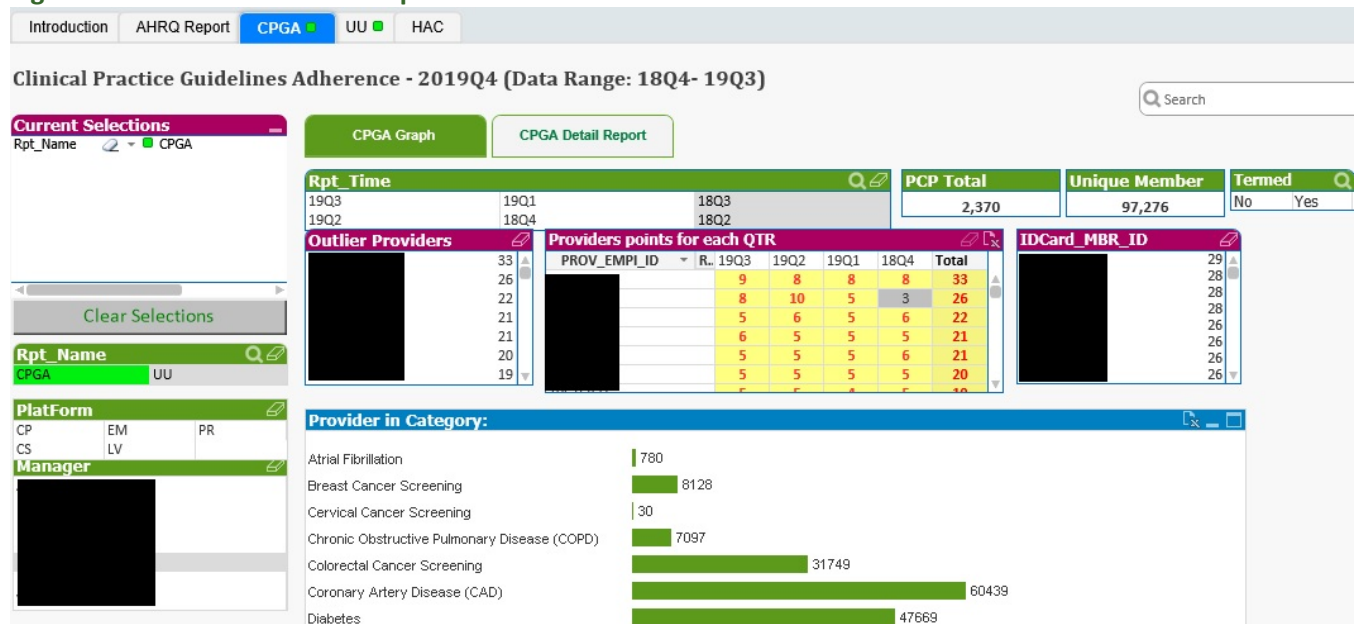|	
i.ii.	Methods for measuring provider performance against practice guidelines and standards adopted by the QIC, and follow up activities to be conducted with providers based on ongoing review of findings.

CPG DEVELOPMENT AND ADOPTION

Humana draws upon the experience and expertise of our national quality team to oversee the development of medical and BH CPGs. Utilizing a centralized approach to CPG development allows us to uniformly disseminate guidelines to our network providers. The Humana CPG Committee, comprised of Humana and external physicians with diverse specialty expertise and backgrounds, researches and reviews the selected guidelines annually. We develop CPGs in consultation with network providers. We will seek input on CPGs from our Kentucky network providers through our **QIC** where providers can provide input and advice on clinical policy development and provider operations.

Our CQIC provides oversight to the implementation, market adaptation, and ongoing monitoring of our CPGs. Our local Kentucky QIC reviews and adopts these CPGs annually.

MONITORING ADHERENCE WITH CPGS

Humana developed the **Clinical Practice Guideline Adherence (CPGA) Report** to evaluate provider adherence to the Humana CPGs. Providers who have a minimum of 30 patient visits for certain conditions are compared to their peers within a particular specialty. Using claims data and our internally developed clinical rules engine, Anvita, patient visits (i.e., opportunities) that meet criteria for each condition are calculated to identify physicians that fall below the average of their peers. Those physicians that are non-compliant and fall in the bottom one percent in two consecutive quarters will appear on this report for quarterly review. Figure I.C.9-6 is a screenshot from our proprietary CPGA Report.

Figure I.C.9-6: Humana CPGA Report

If a provider is identified as an outlier, the practitioner is reviewed by our Kentucky Medicaid Medical Director for consideration of corrective action. This may include provider education, a review of Enrollee medical records, or if the negative trend continues post-education, the development of a corrective action plan (CAP) and presentation to the Peer Review Committee. Any follow-up actions with the providers in question are included in the quarterly reports to the Kentucky QIC. Humana updates providers on changes or additions to CPGs via YourPractice articles, our secure provider portal, Availty.com, and the Humana.com webpage.

In addition to the review of metric reports, Humana conducts **comprehensive medical records reviews to assess practitioner compliance to care guidelines** as they pertain to the delivery of EPSDT services. We will perform a similar record review for EPSDT services in Kentucky.

MONITORING PERFORMANCE AGAINST QUALITY STANDARDS

Through our QIC, we adopt and establish performance standards for our providers, monitoring quality measures regularly through our QIC and Quality Initiative Governance Committee. During our analyses of quality or performance issues, we have the ability to drill down to provider level performance, identify providers with the largest areas of opportunity, and then target educational efforts to those groups. Once we have established measurable targets and goals with providers, having accurate data is vital to tracking progress and analyzing opportunities for improvement. Our Compass tool is designed for these purposes (please refer to sub-question **I.C.9.j.v** for a more detailed description of this tool).

Compass

Humana's proprietary Compass is a valuable tool for providers. Compass compiles utilization, financial, and clinical data with filter functionality, enabling providers to identify patients or groups requiring additional support. These expanded population health data help our providers manage the health of their patients and to better inform their outreach and care. About a dozen core reports are included in Compass, with additional reports available upon request. Of these dozen core reports, we share a core set type to providers:

- Quality reports identify HEDIS gaps in care as established by NCQA guidelines. They are an actionable breakdown of open gaps in care by Enrollee, with specific non-compliance reasons and suggested calls to action to aid providers in gap closure. **HEDIS gaps and analyses are updated weekly**.
- Pharmacy reports include an actionable list of Enrollees who are at risk for non-compliance for medication adherence. **Pharmacy savings and pharmacy coverage data are updated monthly**.

- <u>Census</u> reports identify all attributed patients who are currently admitted into an inpatient care facility. They also identify Enrollees recently discharged from inpatient care. **These analyses are updated daily**.
- <u>Patient detail</u> reports provide an in-depth look at each Enrollee including demographics, visit history, diagnoses, HEDIS gaps, authorizations, physician visits, and clinical program participation.

Providers can access data and reports through the Compass platform at any time. Additional features of Compass include the ability to customize columns to meet the users' needs and desired views. Compass also has a new key performance indicator (KPI) dashboard available to external provider access users. Please refer to **Attachment I.C.9-3** for screenshots of a sample of Compass reports and **Attachment I.C.9-4** for a copy of Compass's product brochure.

FOLLOW-UP ACTIVITIES WITH PROVIDERS BASED ON ONGOING ANALYSIS

Humana's Provider Relations Team, led by our Kentucky Medicaid Provider Services Manager, Michelle Weikel, is a key component of our overall quality strategy and is designed to support providers as they interpret analyses and make informed decisions about closing care gaps and improving quality. Examples of how our Provider Relations Team engages with providers outlined below.

Provider Relations Representatives
Our Provider Relations representatives stand at the center of Humana's interactions with providers. **Provider Relations representatives visit all PCPs and providers in a VBP arrangement at least quarterly**. In these meetings, Provider Relations representatives review reports with providers that highlight their performance relative to their quality targets. They also review gaps in care and make recommendations to providers on possible interventions to help close those gaps. Provider Relations representatives provide information about best practices, and when a current intervention effort is not closing a gap in care effectively, they will troubleshoot with the provider to determine alternate intervention methods.

QIAs
Our QIAs, with their specific clinical expertise, supplement the work of Provider Relations representatives. When performance reports identify underperforming quality measures, they work collaboratively with providers to guide practice-specific strategies to improve quality performance and close gaps in care. Historically, QIAs have had nursing backgrounds. Additionally, with the growth of EHR capabilities and related complexity, we have also added associates with specific expertise in practice systems management.

JOC
We conduct JOC meetings with our large provider groups to review previous periods' quality performance as compared to established quality and utilization outcome targets. During these meetings, we discuss topics including but not limited to health services, quality, HEDIS, medical risk adjustment, pharmacy, provider network, finance, and emerging industry trends. Our JOC meetings are an opportunity to develop and enhance our collaborative partnerships. These meetings offer valuable insight that enables us to evaluate opportunities to improve our provider experience and address specific provider needs. JOC meetings may be scheduled monthly, every other month, or quarterly depending on the needs of the provider network or Humana.

i.iii.	A summary of the Vendor's approach to annual evaluation of the overall effectiveness of the QAPI program and how the Vendor will use findings for continuous quality improvement efforts.

Humana completes a formal annual evaluation of the previous year's QAPI to assess the program's effectiveness. Our **QIE** is an assessment of the effectiveness of the QAPI program and the impact on Humana's PHM strategy. Through cross-departmental collaboration, the QIE outlines accomplishments, includes limitations or barriers to meeting objectives, and provides conclusions and recommendations for the upcoming

year across the organization. The evaluation addresses the structure and functioning of the QAPI program, processes in place, and the outcomes or results of QI activities. We evaluate our QAPI program based on key clinical and operational metrics including but not limited to:

Key Clinical Metrics
- Performance Measures including HEDIS, CMS Adult/Child Core Set measures, AHRQ, EPSDT, and Commonwealth-defined measures
- 3M PPE indicators
- CAHPS Surveys

- PIPs
- Provider Outcome Data
- Clinical Program Outcomes
- Performance Assessment Report
- Practice Guidelines Monitoring

Key Operational Metrics:
- Enrollee satisfaction
- Customer Care Metrics
- Claims Timeliness and Accuracy
- Grievances and Appeals Management

- Assessment of Enrollee Complaints
- Under/Overutilization
- Subcontractor Performance

Both our Kentucky Medicaid and Corporate leadership review the QIE; the findings help to inform strategic priorities and resource allocation for the upcoming year. The Kentucky QIC and the Corporate QIC approve the QIE.

The QIE informs our **QIWP** which (re)prioritizes activities and assists in determining resource needs for the upcoming year. It also serves as a foundation for ongoing management of the QI process. We report the results, barriers, re-measures, actions taken, assessment, analysis to the Kentucky QIC and in the QIE.

> In compliance with Section 19.3 of the Draft Medicaid Contract, we will submit our QAPI Program Plan (that includes our annual evaluation) within 30 days of Contract Execution, and by June 30 each year, and upon request.

j.	Provide a summary of how the Vendor will collaborate with the Department and other Vendors in developing and implementing a value-based payment (VBP) program. Include proposed approaches for the following at a minimum:

j.i.	The Vendor's lessons learned in developing and implementing VBP models, examples of models that have been most effective in improving performance and outcomes.

Approximately 3.2 million Humana Enrollees are receiving care from providers engaged in VBP arrangements, including more than one million Enrollees managed in full-value risk arrangements. Constant evaluation of the results of our VBP models have afforded us many valuable lessons, helping us develop innovative models with quantifiable success, ultimately improving quality performance and health outcomes. We will bring the knowledge gained from these lessons to discussions with the Department and other Vendors as we collaborate together to design and implement a VBP program.

LESSONS LEARNED

Tailored Programs
Value-based care is embedded throughout Humana's operations. We believe in rewarding strong performance regardless of practice size or provider type. A one-size-fits-all approach will not allow the diverse provider community to be successful in VBP, so **we have learned to meet providers where they are by offering programs tailored to their current capabilities**. For PCPs, we offer a continuum of VBP programs – called the Path to Value – that aligns with each provider's unique experience, size, infrastructure, needs, and goals. In our experience,

PCPs play a particularly powerful role in influencing an Enrollee's health. For this reason, we believe in and create VBP models that deeply integrate PCP practices.

We also believe that VBP opportunities should not be limited to PCPs. We will offer programs designed specifically for OB/GYNs, BH providers, and other specialists. Regardless of the provider type, it is important that we are flexible and willing to refine or adjust a program's underlying quality metrics, according to provider feedback and analysis of metric effectiveness.

Meaningful Incentives
The shift from fee-for-service (FFS) to pay-for-value requires providers to invest in new capabilities and quality improvement activities, and **MCOs need to offer meaningful incentives to justify the costs**. This is especially important for PCPs that may be capable of advancing into shared savings and full-value risk arrangements. These advanced VBP arrangements have the greatest impact to health outcomes, but they require more accountability from providers. As a result, we have learned to offer incrementally greater financial opportunities for providers as they progress along a VBP continuum of offerings. We offer a Practice Transformation Incentive (PTI) for providers to upgrade their infrastructure and technology so they will be more prepared for the additional responsibilities and requirements that are inherent in shared savings and risk arrangements.

Ongoing Training and Support
For providers to be successful in VBP programs, we have learned that comprehensive, ongoing training and support is critical. Orientation is important for providers to understand the program structure, underlying measures, and incentive opportunities. Afterward, quarterly meetings to review performance, offer recommendations, and answer questions will help providers achieve quality targets. More importantly, providers need actionable data to identify care gaps. These data need to be synthesized into easy-to-understand reports that will be shared in quarterly meetings, and they need to be available on demand through an accessible provider portal.

Similarly, we have learned that practices with a "physician champion" have greater success in VBP. Provider groups in VBP arrangements will often designate one internal leader to be a voice to the strategic and operational planning for VBP. As a trusted colleague, physician champions can help providers throughout a practice understand quality measures and how to improve performance on a daily basis.

Deliberate Quality Measure Selection
When selecting underlying quality measures for VBP programs, we have learned that "less is more." If providers are held accountable for dozens of quality measures, they may feel helpless and overwhelmed, which can lead to disengagement. When VBP incentives are tied to a short list of measures, providers develop an in-depth understanding and invest in targeted initiatives to improve performance.

VBP quality measures should reflect covered populations, priorities of the Medicaid agency, and local health needs. Quality measures and associated benchmarks need to be relevant to the provider type and the population they serve. Benchmarks for each measure should be set such that they are challenging yet attainable. At the end of each year, measures should be re-evaluated based on local trends, guidance from CMS, and provider performance. If necessary, adjustments should be made to selected measures and providers need clear communication to understand the changes.

As we designed our VBP Strategic Plan for Kentucky Medicaid, we followed the lessons described above. The result is a focused, deliberate package of measures that speaks to the health needs of Kentucky's communities. As more information regarding the Commonwealth's prioritized measures is released, and as we continue to learn from our engagements with providers, we will refine and improve our selected measures.

EXAMPLES OF EFFECTIVE VBP MODELS

Florida Medicaid Medical Assistance (MMA) Physician Incentive Program
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 are required to participate in the program, called the 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 took a collaborative and 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 to ensure the VBP program meets the State's goals, such as reducing preventable ED visits and hospitalizations and improving birth outcomes. 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 to improve health outcomes, such as ED visit rates and HEDIS measures regarding prenatal care. As a result of this collaborative approach, the MPIP program has been successful in engaging and recognizing providers for excellent performance. From 2016 to 2018:

- The number of PCPs who 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%

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

> " Humana is a vital part of our practice providing personalized service for our doctors, staff, and our patients. The union we share assuredly produces high quality healthcare and positive outcomes for everyone involved. Their exceptional commitment is unmatched by other insurance companies. "
>
> – Debbie Emmons, Morehead Primary Care

> " 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. "
>
> – Scott Farr, Chief Operating Officer, Pediatric Associates

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 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%**.

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 risk 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 then support 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 then help them develop the infrastructure and resources necessary to be successful in more advanced risk arrangements.

j.ii.	Recommended goals and focus areas in the first two years of implementation of the VBP program.

In order to plan and prepare for implementation of the VBP program, it is important to set goals and identify areas of focus to serve as guideposts to the development of the program. Based on our experience designing and implementing VBP programs, we recommend the following goals and focus areas.

GOALS

Developing and improving VBP models is an ongoing process. Enhancing VBP is more successful when done in conjunction with other stakeholders, especially other MCOs and the Department. We have identified a number of collaboration-based goals for Kentucky, which would meaningfully affect the implementation of a VBP

program if accomplished. Our recommended objectives are grouped into two broader categories: (1) establishing meaningful communications and (2) aligning program parameters.

Establish Provider Communication Strategy

Successful VBP depends on collaborative relationships with providers, built on transparent, clear communications. **We strongly recommend having the goal of establishing a provider communication strategy as a centerpiece in the implementation of a VBP program in Kentucky**. There are several important sub-goals and tactics that will directly influence the overarching objective of establishing meaningful communications:

- Develop orientation plan: Clear communication is essential when new initiatives or programs are executed with providers. In other words, providers should not be surprised by the introduction of the VBP program but should be prepared and ready to engage. Before the program officially begins, providers need to be well-informed of the VBP program's offerings, how it affects them, and what they need to do to get started in the program. We recommend that MCOs and the Department collaborate together to **develop an orientation plan and clear timeline** to help educate providers about the program.

- Create training toolkits: In addition to clear communication about program elements and implementation timing, providers should have additional resources to find answers to questions, see more detailed information about reporting and financial incentives, and study best practices for navigating participation in VBP. Creating a training toolkit, assembled by compiling MCO and Department knowledge, will empower providers to develop internal processes to be successful in the VBP program.

- Host town hall meetings: Receiving input and feedback from the provider community is an essential element of establishing a collaborative dialogue about VBP. Prioritizing provider feedback is important because it will help providers feel more engaged in the development of the VBP program, which will improve engagement when the program is implemented. We recommend that MCOs and the Department **host periodic, regional town hall meetings wherein providers can voice their input** and the Department and MCOs can listen and learn. These meetings should occur before and after the program is implemented. This will provide input into the design of the program, as well as feedback on how providers are experiencing the program, which could lead to opportunities for improvement.

Aligning Program Parameters

VBP program design details, such as program type, payment timelines, and performance targets, should be thoughtfully defined. For the implementation of the VBP program to be successful, **we recommend the goal of aligning program parameters**, which should be informed by the collective experiences of MCOs, as well as the Department's experience and priorities. There are several key strategies to confirm VBP program details during the first two years of implementation:

- Select VBP program types: Many different VBP models exist, and each is customizable according to program goals. **We recommend that the Department collects feedback from MCOs on which types of programs are most appropriate** for Kentucky's various communities and regions. Possible program types include bonus programs, shared savings arrangements, and full-risk models. This discussion should also include determining which provider types should be included in the VBP program.

- Develop implementation timeline: During the first two years of program implementation, we recommend **defining a clear and purposeful schedule for the VBP program**, especially if the Department intends to offer different types of programs. For example, it may be prudent to stagger the implementation of different programs, beginning with less complex bonus programs, then steadily implementing more advanced models, like shared savings arrangements. It is important not to overwhelm providers during implementation, so establishing a clear timeline will help providers engage in the program without feeling rushed or forced into an initiative for which they have not prepared.

- Align on operational details: To reduce administrative burden and provider confusion, it is important for MCOs and the Department to align on important operational details, such as the selection of quality measures and eligibility requirements. During the first two years of program implementation, we recommend that the Department and MCOs **coordinate to select quality measures** that align with local

health needs and that will drive improvements in health outcomes. After the program is operational, we encourage the regular review of these measures to evaluate their effectiveness and determine if adjustments need to be made, either by adjusting the associated performance targets or replacing the metric with a more suitable measure. We also recommend the Department identify other relevant operational elements, such as incentive payment timing and panel size requirements, in collaboration with MCOs.

These goals are most likely to be achieved when providers, the Department, and MCOs work together. We have also identified recommended focus areas that complement and inform the goals described above.

FOCUS AREAS

Based on our experience designing and administering VBP programs across the country, we have identified a few areas of focus that we recommend to the Department for consideration as a VBP program is developed and implemented in Kentucky. **The focus areas we recommend are health outcomes that relate directly to the Triple Aim**: Improve the Health of Populations (better health), Enhance the Experience of Care for Individuals (better care), and Effectively Manage Medicaid Per Capita Care Costs (better value). These focus areas include increasing access to primary preventive care, improving delivery of integrated care, and reducing PPEs.

Increase Access to Primary Preventive Care
Incentivizing measures such as well child and adult visits through value-based care curtails the development of preventable chronic conditions, including vaccine-preventable diseases and lifestyle-related conditions. PCPs play a vital role in this effort, which is why PCPs and preventive care measures are central to Humana VBP models. We recommend **incentivizing measures related to preventive care** as the Kentucky Medicaid VBP program is developed and implemented.

Improve Delivery of Integrated Care
Physical health and BH conditions are often interconnected, and more than one quarter of Humana's Kentucky Medicaid Enrollees have a BH condition. Integrating the treatment of behavioral and physical health in one location can improve access to BH care for Enrollees with mild to moderate BH conditions. This is another area of focus that we recommend for the development of the VBP program. In our experience, there are a variety of ways and measures to incentivize providers to integrate behavioral and physical health in their practices. We have also learned the importance of having BH training available to PCPs who are less experienced or not as comfortable treating BH. We will gladly share our experience with the Department and other MCOs as the VBP program is designed and implemented.

> Humana recently sponsored a study wherein **63% of providers** reported that SDOH needs do not play an important role in their organizations' overall strategy or cost planning.

Reduce Potentially Preventable Events
By holding PCPs accountable for potentially preventable ED visits, hospitalizations, and readmissions, providers are encouraged to consider Enrollees' overall well-being, especially as it relates to SDOH. An Enrollee who struggles with homelessness, for example, is more likely to experience behavioral and physical health issues that lead to ED visits and hospitalizations. The close connection of **managing SDOH in order to reduce PPEs** is just one reason we recommend this as a focus area for developing and implementing the VBP program.

j.iii.	Proposed approaches to collaborate with the Department and other MCOs to develop the VBP program and to implement a coordinated approach to achieve statewide improvement in outcomes.

Collaborating with other MCOs and the Department will play an important part in developing an impactful VBP program. In order to collaborate successfully and achieve goals, it is necessary to have appropriate forums for

discussion and ideation. We have learned valuable lessons from collaborations in other markets and propose some of the more effective approaches below. These approaches include establishing a regular meeting cadence with clear objectives and decision points and including local associations in discussions.

Collaboration Meetings

Humana is proposing monthly one-on-one meetings with DMS and each MCO, as well as quarterly meetings with all MCOs, DMS, and other agencies. Face-to-face meetings with the Department and representatives from MCOs should serve as the backbone of discussions to design the VBP program. For these meetings, clear agendas and objectives should be prepared and disseminated ahead of time so all participants can prepare adequately and provide meaningful insights. In this forum, MCOs can share best practices and past VBP experience. This is also an excellent forum for the Department to share more detail about its priorities and for MCOs to offer their perspectives.

Soliciting Input from Providers

Local healthcare and physician associations are very well-connected and in-tune with the communities they serve and providers they represent. In addition to the proposed goals above, where we propose goals for the development and implementation of the VBP program, **we recommend holding town hall provider meetings**. The objective of these meetings is to invite providers to offer feedback and input on possible VBP program design and measure selection. Local healthcare and physician associations can also be invited to participate in these types of meetings and provide a unique perspective on VBP program structure.

Humana will host a Provider Advisory Committee (PAC), including a BH Subcommittee, to help guide provider communication and education strategy. Co-chaired by our Chief Medical Officer, Dr. Galloway, MD, and BH Medical Director, Ms. Stearman, CSW, MSSW, the PAC will comprise diverse provider types and community leaders, such as a representative from one of Kentucky's State-operated or contracted psychiatric hospitals. The PAC will give providers a forum to speak openly and share feedback about Humana, our operations, and the MMC program overall. We will also use the PAC as an opportunity to share updates and information with providers. In our other markets, the PAC is a crucial component of our education strategy, informing both content and delivery method decisions. The BH Subcommittee advises Humana on our approach to the integration of BH and physical health services. This forum may serve as a model for other provider town hall meetings and can serve as another tool to collect valuable insights and inform development of the VBP program.

We suggest the Department and MCOs coordinate to create a Request for Information (RFI) as a tool to collect valuable insights about providers' experience and ideas regarding the VBP program. This would provide an alternative means of gathering feedback from providers who otherwise may be uninterested or unavailable to attend an in-person session. In a similar fashion, once the program is operational, we suggest developing a uniform satisfaction tool or survey that includes questions about providers' satisfaction with the VBP program. Having such a tool would both alleviate provider burden from having to fill out multiple satisfaction surveys, as well as provide a standardized input channel where MCOs and the Department could learn about provider experience with the VBP program.

Provider associations may also play a valuable role in disseminating information about the VBP program to providers. If the associations participate in the development of the VBP program, they will be well-informed, connected, and able to keep providers informed about the program's progress and details.

j.iv.	Potential challenges specific to Kentucky and the Vendor's proposed methods for addressing identified challenges.

There are unique challenges in Kentucky that affect providers' ability to engage in and experience success with VBP. We have considered how these challenges impact the success of VBP programs and have identified solutions to mitigate their effects. **Table I.C.9-9** outlines challenges and the solutions we propose.

Table I.C.9-9: Challenges and Solutions for VBP in Kentucky

Example 1	**Challenge**: Practices with small membership panels have limited ability to participate in advanced VBP models, such as shared savings or full risk. If a small practice were to participate in a full-risk model, for example, a single Enrollee with significant and unavoidable healthcare costs will have a much greater negative impact on the practice's financial results than an Enrollee in a practice with a larger panel size.
	Solution: As part of the broader VBP programming, we propose developing a no-risk, rewards-only model that incentivizes providers to meet predetermined quality targets. This model would have a smaller panel size requirement (approximately 30 Enrollees), which would enable Kentucky's small and large practices alike to participate in VBP, even if the smaller practices were to not participate in shared savings or full-risk programs. This would also serve as an excellent entry point for larger providers who are new to VBP and may not be ready for shared savings or risk arrangements.
Example 2	**Challenge**: It is more difficult for Provider Relations representatives to hold regular in-person meetings with providers in Kentucky's rural areas to review VBP reports and progress.
	Solution: We recommend the use of teleconference tools for face-to-face meetings when in-person meetings are not feasible. We also suggest a funding opportunity that will help providers implement technology upgrades that would enable online and digital interactions with Provider Relations representatives and Enrollees. It is also important that providers be able to access performance reports at any time. We ensure that our Provider Relations representatives train providers to use our proprietary tool, Compass, so they can access their measurement reports whenever it is convenient for them.
Example 3	**Challenge**: Kentucky's MMC covered populations are diverse, and so are the types of providers who serve Medicaid Enrollees.
	Solution: Having a uniform, one-size-fits-all VBP program does not allow the necessary flexibility to accommodate the diversity of the Medicaid population and various provider types. To address this challenge, we suggest employing different sets of measures within VBP programs for different PCPs, depending on the provider's feedback, their region, and the mix of Enrollees on their panel. For example, adult-specific measures should be used for PCPs who care primarily for adult Enrollees and children-specific measures for pediatricians. This approach also applies to BH and other specialty providers. It is important to ensure providers are able to impact the measures assigned to them.
Example 4	**Challenge**: Some providers are skeptical about VBP and whether it is worth the effort to participate.
	Solution: It is important to provide robust tools and resources to providers in order to ensure they can be successful in VBP programs. First, we have also learned the value of assigning a designated Provider Relations representative to providers, whether they are in a VBP arrangement or not. Their Provider Relations representative serves as an advocate of the VBP program and can help educate providers on the offerings, financial incentives, and positive improvements in health outcomes that are associated with participating. They also answer questions and can help providers take the first steps to engage in the VBP program. Second, we have also learned providers need accurate, timely data to understand their performance and make improvements over time. As discussed in greater depth in sub-question I.C.9.j.v of this response, Compass, Availity, and Service Fund offer providers access to data that can help them better manage the health of their patients and, as a result, improve their performance in VBP programs.

j.v.	Regardless of the model implemented, the Vendor's approaches to analyzing performance against targets, frequency of analyses, reporting results to DMS, and use of analyses to modify interventions that are not making progress towards achieving targets.

During our years of experience administering VBP programs, we have developed tools to capture data, analyze performance against targets, and help providers modify health interventions, as necessary. We propose using these tools in the Kentucky Medicaid VBP program to help achieve the Department's objectives and drive positive health outcomes for Enrollees.

ANALYZING PERFORMANCE

Once we have established measurable targets and goals with providers, having accurate data is vital to tracking progress and analyzing opportunities for improvement. The following three tools, Compass, Availity, and Service Fund, are designed for these purposes.

Population Insights Compass
Humana's proprietary Compass is a valuable tool for providers. Through our robust data-sharing capabilities, we are able to provide additional insight into their patients. These expanded population health data help our providers manage the health of their patients and to better inform their outreach and care.

Compass compiles utilization, financial, and clinical data that can be filtered to enable providers to identify patients or groups requiring additional support. About a dozen core reports are included in Compass, with additional reports available upon request. Captured below are our main types of reporting we share with our providers today:
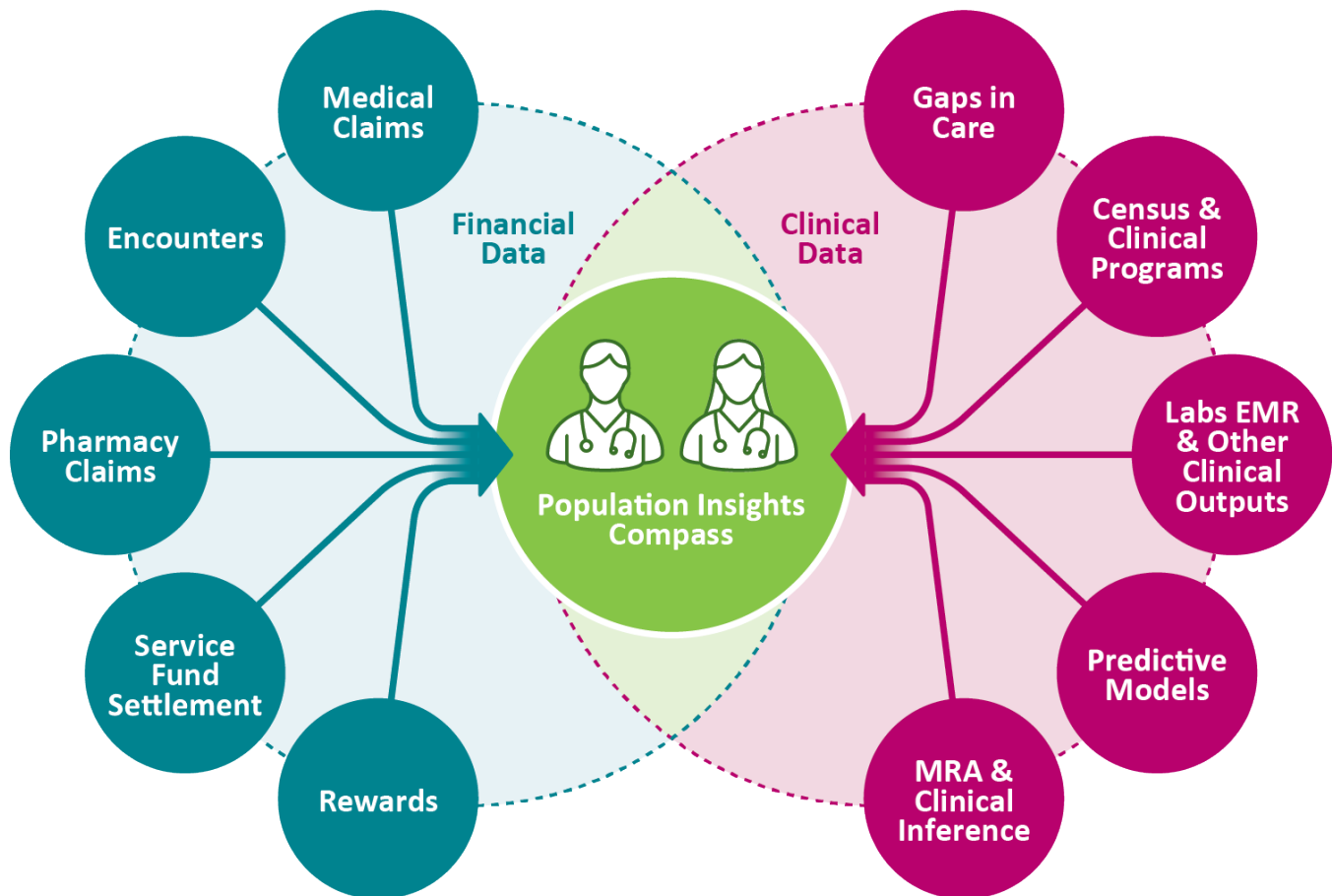
- Quality reports identify HEDIS gaps in care as established by NCQA guidelines. They are an actionable breakdown of open gaps in care by Enrollee, with specific non-compliance reasons and suggested calls to action to aid providers in gap closure. Quality reports also include a detailed, comprehensive view of Humana patients who suffer from diabetes, including testing for nephropathy, body mass index (BMI), and medication adherence. **HEDIS gaps and analyses are updated weekly**.
- Pharmacy reports include an actionable list of Enrollees who are at risk for non-compliance for medication adherence. In addition, these reports show percentage of days covered and list the actual pharmacy where Enrollees have their prescriptions filled. They also help identify opportunities to improve adherence by encouraging mail order delivery or 90-day refills, when appropriate. **Pharmacy savings and pharmacy coverage data are updated monthly**.
- Census reports identify all attributed patients who are currently admitted into an inpatient care facility. They also identify Enrollees recently discharged from inpatient care. **These analyses are updated daily**.
- Patient detail reports provide an in-depth look at each Enrollee including demographics, visit history, diagnoses, HEDIS gaps, authorizations, physician visits, and clinical program participation.

Providers can access data and reports through the Compass platform at any time. Additional features of Compass include the ability to customize columns to meet the users' needs and desired views. Compass also has a new KPI dashboard available to external provider access users. For Kentucky, we will configure our VBP platform and reporting to ensure prompt sharing of data and minimize administrative burden for our providers.

In addition, within Compass, the Provider Relationship Management (PRM) tool allows Humana's Provider Relations Team to log and track contacts with provider groups by line of business. This documentation offers granular yet important engagement details, such as specific topics discussed (e.g., financial, quality, pharmacy, health programs, patient safety, coding, provider concerns, and preventive measures). It also allows for documentation of provider action plans to aid providers with Enrollee health management. Additionally, any documents pertinent to the provider contact can be uploaded here. The PRM tool is tracked by Humana to ensure adequate provider contact and outreach.

Please see **Attachment I.C.9-3** for a brief overview of Compass, including screenshots of sample reports. Also, please see **Attachment I.C.9-4** for an informational brochure highlighting Compass's capabilities and tools.

Figure I.C.9-7: Populations Insights Compass

Availity

Humana's provider portal assists providers in their efforts to achieve optimal performance under VBP arrangements. Providers benefit from having a single location and consistent workflow to process transactions and securely access a wide range of financial, administrative, and clinical transactions.

- The practitioner assessment form (PAF) is a comprehensive health assessment form to help providers document vital information for patients during a face-to-face physical examination. The PAF is a valuable tool to assist in closing care gaps through improved coordination of care.
- Availity's Payer Spaces allows Humana to securely deliver information to providers. We have developed proprietary applications within Payer Spaces to partner effectively with providers and share clinical information. Humana's Care Profile application enables providers to view attributed Enrollees' **Contact Information, Assessments, and Care Plans**. Our Medical Record Management application enables seamless **sharing of medical record information, including ADT data in near real time**, between healthcare providers and our care management teams through our direct connection with EHRs.
- Availity 360 supports providers in understanding their overall performance, supplying up to 12 months of aggregate information across a number of dimensions. We use reports from Availity 360 to evaluate transaction volumes; identify **high utilizers**; analyze error and denial trends; recognize patterns that may indicate fraud, waste, and abuse (FWA); and generate reports based on specific criteria (such as belonging to a disease registry).

Service Fund – Risk Sharing Analytics

Humana has developed Service Fund, a proprietary risk-sharing management application for providers engaged in a risk or capitated arrangement. We use this innovative tool to calculate reimbursements to providers in these arrangements by tracking and aggregating information on capitation payments, claims expensing, claims payment, reconciliation, and settlement for all PCP contracts. Service Fund makes **monthly data files** available containing information regarding provider membership, funding, claims activity, progress toward VBP targets, and capitation payments at both individual provider and group levels. Humana tailors the reports to providers in risk- or value-based arrangements. Providers can access these reports through an online portal as well as through our Provider Relations representatives. Humana also educates providers using Service Fund by walking through standard reports during initial training to show providers the data they can access and how to use it to help manage their financials. We will use this application and our financial modeling capabilities to communicate transparently to providers about the information they need to fully comprehend and the opportunities and risks associated with participation in our shared risk arrangements.

USE OF ANALYSES TO MODIFY INTERVENTIONS

Humana's Provider Relations Team is designed to support providers as they interpret analyses and make informed decisions about closing care gaps. Examples of how our Provider Relations Team engages with providers are as follows.

Provider Relations Representatives

Our Provider Relations representatives stand at the center of Humana's interactions with providers. Humana supports providers by ensuring each provider has a single "relationship quarterback" who is responsible for all provider education training, data, and support needs. **Provider Relations representatives will visit all PCPs and providers in a VBP arrangement at least quarterly**. In these meetings, Provider Relations representatives review reports with the providers who highlight their performance against their quality targets. They also review gaps in care and make recommendations to providers on possible interventions to help close those gaps. Provider Relations representatives can also provide information about best practices, and when a current intervention effort is not closing a gap in care effectively, will troubleshoot with the provider to determine alternative intervention methods.

Quality Improvement Advisors

QIAs, with their specific clinical expertise, supplement the work of Provider Relations representatives. When performance reports identify underperforming quality measures, they work collaboratively with providers to guide practice-specific strategies to improve quality performance and close gaps in care. Historically, QIAs have had nursing backgrounds. Additionally, with the growth of EHR capabilities and related complexity, we have also added associates with specific expertise in practice systems management.

REPORTING RESULTS TO DMS

We understand the value of transparently sharing VBP results and progress with the Department. To facilitate informative, efficient reporting we recommend reporting results on a quarterly basis in a standardized, electronic format. Within the report, we suggest including a statewide summary of results accompanied by regional analyses. Identifying top-performing providers, as well as those who are underperforming, would be another part of the report.

We also suggest including key challenges, success stories, and lessons learned. Based on trends or issues from the previous quarter's data, we recommend outlining the key areas of focus that the Vendor will focus on over the next quarter. The key areas of focus will help inform the Vendor's outreach to providers as part of efforts to close gaps in care and improve performance results.

k.	Will the Vendor and Subcontractors implement VBP arrangements with providers? If so, describe the following:

Humana has been a leader in establishing VBP programs for more than 30 years and was one of the first health plans nationwide to partner with providers to develop these 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 payment models that support our providers' practice transformation initiatives. **Today, Humana has more than 52,000 PCPs in value-based agreements across 43 states. In Kentucky, approximately 81% of our MA Enrollees are attributed to PCPs in value-based arrangements**. We 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, 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 MA value-based arrangements across a variety of HEDIS measures, as compared to providers in our MA FFS arrangements.

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

Advancing achievement of the "Triple Aim" – better health, better care, and better value – through VBP is only possible when providers and health plans collaborate. Humana has developed our Kentucky Medicaid VBP strategy to foster this collaboration, and our longstanding provider relationships statewide will enable successful implementation of our Medicaid VBP programs.

k.i.	The types of VBP arrangements the Vendor and Subcontractors plan to use and why these models were selected. As part of your description, map your proposed VBP arrangement to the HCP-LAN APM Framework maturity level.

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 and 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 as providers at each level progress along the path toward full value. Humana will offer VBP models for PCPs, BH providers, OB/GYNs, and specialists.

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

Table I.C.9-10 provides an overview of our intended VBP offerings, mapped to the HCP-LAN APM framework.

Table I.C.9-10: Growing Value-Based Purchasing for Kentucky Medicaid

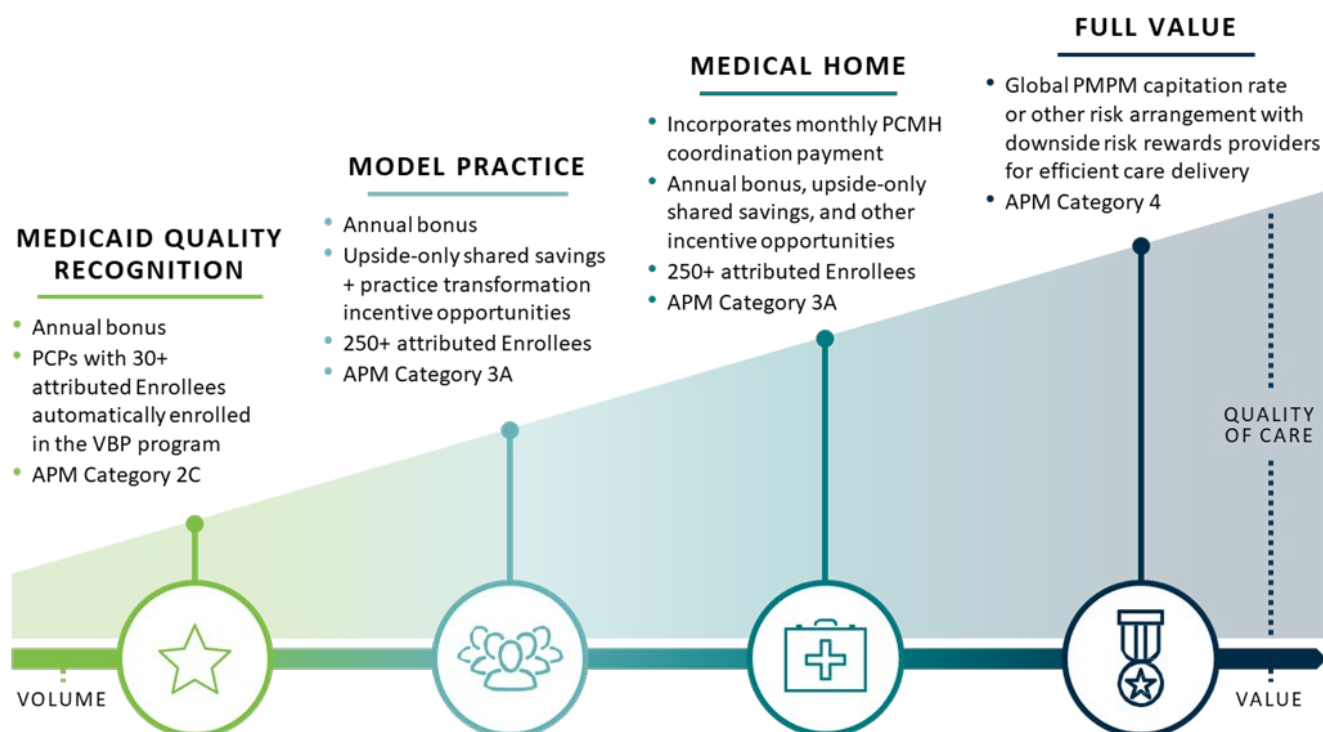| Provider Type	APM Level	Detail
Primary Care Providers (PCPs)	2. Rewards Only	Medicaid Quality Recognition: Bonus for meeting quality and outcomes metrics
	3. Shared Savings	Model Practice: Bonus payment for meeting quality and outcomes metrics *Potential for upside-only shared savings *Practice Transformation Incentive (PTI)
	3. Shared Savings	Medical Home: Bonus payment for meeting quality and outcomes metrics *Potential for upside-only shared savings + PTI *Monthly care coordination payment [for practices with Patient-Centered Medical Home (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	Maternity VBP: 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	Bundled Maternity Payments with quality metrics
	4. Full Risk	N/A
Behavioral Health (BH)	2. Rewards Only	BH Integration Referral Incentive Rapid Access Bonus BH Medical Home Incentive
	3. Shared Savings	Bundled Payment: Case rate for Medication-assisted Treatment (MAT)
	4. Full Risk	N/A
Other Specialist	2. Rewards Only	N/A
	3. Shared Savings	Bundled Payments: Total Joint Replacement, Spine Surgery
	4. Full Risk	N/A
Additional Incentives Program		
Extended Hours Bonus	██	

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 providers 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.9-8 Humana's Path to Value

FULL VALUE
- Global PMPM capitation rate or other risk arrangement with downside risk rewards providers for efficient care delivery
- APM Category 4

MEDICAL HOME
- Incorporates monthly PCMH coordination payment
- Annual bonus, upside-only shared savings, and other incentive opportunities
- 250+ attributed Enrollees
- APM Category 3A

MODEL PRACTICE
- Annual bonus
- Upside-only shared savings + practice transformation incentive opportunities
- 250+ attributed Enrollees
- APM Category 3A

MEDICAID QUALITY RECOGNITION
- Annual bonus
- PCPs with 30+ attributed Enrollees automatically enrolled in the VBP program
- APM Category 2C

QUALITY OF CARE

VOLUME   VALUE

Medicaid Quality Recognition

The first step on our Path to Value is the Medicaid Quality Recognition (MQR) program. The MQR program incents provider behavior, such as screening for breast cancer or conducting annual wellness visits, by offering an annual bonus to PCPs meeting quality and outcomes goals across a set of pre-determined 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 program, 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 pre-determined 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 ED, for example. We make payments for achievements in the Model Practice program on an annual basis.

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

Providers in shared savings are inherently incentivized to consider the impact of 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 CMs who will connect Enrollees with appropriate 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 Health, 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 Patient Centered Medical Homes (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 practices and using EHRs.

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 UTC Enrollees. 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.

> Humana's 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.

To protect Full Value providers from excessive downside risk, Humana follows CMS's 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 BH 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 i███. 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

BH Integration Referral Incentive

Enrollees with BH needs, particularly those with SMI, 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 child/adult visits, diabetes care, and 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. ███████████████████████████████████████ ███████████████████████████████████████ ███████████████████████████████████.

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

Humana will continually solicit input from participating BH providers in the Rapid Access Program and/or BH Integration Referral Incentive 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., hire 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, 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.[36] 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"**. ▌▌▌

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. ▌▌

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

k.ii.	How improvement in health outcomes will be addressed through the VBP arrangements implemented.

Each stage of our value-based continuum has quality measures and incentives designed to achieve specific outcomes related to the Triple Aim. Humana's VBP strategy is designed to improve outcomes across an array of clinical and efficiency metrics.

AIM 1: IMPROVE POPULATION HEALTH

OUTCOME 1: Increase Access to Primary Preventive Care
Associated measures:

- Adults' access to preventive/ambulatory health services
- Childhood access to primary care
- Weight assessment and counseling
- Well-child visits
- Immunization rates
- Smoking and tobacco use cessation

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[36] Appalachian Regional Commission, Fact Sheets: Health Disparities in Appalachia. August 2017. https://www.arc.gov/images/appregion/fact_sheets/HealthDisparities2017/KYHealthDisparitiesKeyFindings8-17.pdf.

Through our VBP measures targeting well-child and adult visits, Humana aims to curtail the development of preventable conditions, including vaccine-preventable diseases and lifestyle-related conditions. To promote primary preventive care among our adult Enrollees, we will incentivize PCPs to ensure that attributed Enrollees receive an annual well-adult visit under the **Adults' Access to Preventive/Ambulatory Health Services** measure. Among adults, regular PCP visits for preventive health services are essential for detecting and treating minor illnesses before they cause serious problems and for encouraging behavior change, such as smoking cessation and increased physical activity. To further emphasize the importance of addressing smoking and tobacco use, we will tie incentives to the **Medical Assistance with Smoking and Tobacco Use Cessation** measure. Recognizing the link between obesity and a number of prevalent conditions, including diabetes and hypertension, we will also reward PCPs for conducting an **Adult BMI Assessment**. To ensure that adults who have an unhealthy BMI connect with appropriate services, we will accompany our VBP programs with education on Humana's weight management health coaching program to encourage referrals.

Our approach to preventive care among our pediatric Enrollees will also emphasize regular PCP visits. To this end, we will offer incentives tied to measures including **well-child visits within the first 15 months of life (six or more visits); well-child visits in the third, fourth, fifth, and sixth years of life; childhood access to primary care – seven to 11 years**; and **adolescent well-care visits**. To promote appropriate care delivery during these visits and reduce the incidence of vaccine-preventable diseases, including cervical cancer, we will offer rewards tied to **childhood immunization status and immunizations for adolescents**. To address the rate of obesity among Kentucky's children and adolescents (where approximately 17% of children aged 2 to 19 years are obese), PCPs will also be eligible to receive an incentive for offering **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition Counseling**.

OUTCOME 2: Improve Birth Outcomes		
Associated measures:		
• Preterm birth rate	• Infant mortality	• Maternal morbidity and mortality

To support early detection of pregnancy and appropriate referrals for prenatal care, **we will offer all providers an incentive for each completed Notification of Pregnancy form for a Humana Enrollee**. Upon receipt of this form, we can ensure that the woman has made an appointment for (or completed) her first prenatal care visit and that she connects with our MomsFirst maternity care management program.

Additionally, we will offer an incentive for the HEDIS measure **Timeliness of Prenatal Care**, which supports completion of the first prenatal care visit within the first trimester of pregnancy or within 42 days of enrollment with Humana. The U.S. Department of Health and Human Services' Office on Women's Health reports that babies born to mothers who receive no prenatal care are three times more likely to be born at a low birthweight and five times more likely to die.

We also aim to improve birth outcomes by promoting full-term, vaginal deliveries whenever possible. We will tie provider rewards to their performance managing **Cesarean-section rates for low-risk, first-birth women**. Finally, we will incentivize **postpartum care visits**. Provision of postpartum care is essential to both the health of the mother – including her mental health and management of chronic conditions – and the infant. This includes advice on breastfeeding and infant care.

OUTCOME 3: Reduce Morbidity and Mortality	
Associated measures:	
• Cancer screening rate	• Chlamydia screening rate

Our VBP model aims to promote prompt detection and treatment of disease to reduce associated morbidity and mortality. Cancer screenings, in particular, have the potential to drastically reduce mortality. To ensure that our

adult Enrollees receive recommended screenings, we will incentivize completion of **breast cancer screenings** and **cervical cancer screenings** among our providers. Furthermore, by encouraging regular PCP visits for adults, we expect to see higher rates of screening and detection of common conditions, including diabetes, hypertension, and heart disease. By tying monetary rewards to cancer screenings and well-adult visits, we will encourage our providers to make extra efforts to bring Enrollees in for these screenings and to conduct these screenings (when possible) during routine well-adult visits and other Enrollee appointments.

In addition to cancer screenings, we will incentivize completion of **chlamydia screening in women**. Screening for chlamydia reduces the complications of chlamydial infection, including pelvic inflammatory disease. In addition, it reduces the risk of passing the infection to an infant during delivery.

AIM 2: ENHANCE THE EXPERIENCE OF CARE FOR INDIVIDUALS

OUTCOME 1: Improve Delivery of Integrated Care
Associated measures:

• PCPs completing depression screening	• PCPs following ADHD treatment guidelines	• Enrollees with serious and persistent mental illness (SPMI) completing annual PCP visit

Humana has designed our VBP model to foster the integration of physical and behavioral health in the primary care setting. We will reward our PCPs for the screening and management of mild to moderate BH conditions with the goal of improving integrated care delivery and expanding access to BH care. To promote appropriate screenings, appropriate referrals, and delivery of ongoing care, we will reward PCPs in all VBP arrangements for **Depression Screening and Follow-Up for Adolescents and Adults**. For PCPs in our Model Practice and Medical Home arrangements, we will provide rewards tied to their performance on two key ADHD metrics: **Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase** and **Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase**. With these incentives, we aim to improve PCP adherence to best practice standards for the treatment of ADHD. In addition, we will offer PCPs in these arrangements an incentive tied to **Antidepressant Medication Management** to promote appropriate monitoring of medication adherence, side effects, and treatment effectiveness.

In addition to a focus on those BH conditions that can be treated within the PCP's office, we will also emphasize appropriate physical healthcare for Enrollees with SPMI through our VBP models for BH providers. Our network BH providers who opt into our BH Integration Referral Incentive program can earn a **bonus for each attributed Enrollee who has four BH provider visits and at least one PCP visit** within a one year period. In addition, our BH providers will be eligible to receive a BH Medical Home Incentive payment for inclusion of primary care services in their practice (e.g., through the hiring of a PCP).

OUTCOME 2: Improve Treatment of Chronic Conditions
Associated measures:

• HbA1c levels	• Blood pressure levels

Humana recognizes the important role of PCPs in chronic condition management. Therefore, we will incentivize a number of related metrics through our VBP models to improve the treatment of those chronic conditions that most frequently afflict Medicaid Enrollees, including adults in the expansion population:

- Diabetes: According to a recent American Diabetes Association report, approximately 15.3% of adult Kentuckians have been diagnosed with diabetes. We will reward PCPs in our Medicaid Quality Recognition, Model Practice, and Medical Home models for their performance on important diabetes control metrics, including **Comprehensive Diabetes Care – HbA1c testing** and **Comprehensive Diabetes Care – Poor Control (HbA1c > 9.0%)**.

- Hypertension: DPH's 2019 Kentucky Diabetes Report indicates that 43% of MMC Enrollees, ages 18 to 85, with hypertension did not adequately control their blood pressure levels. To promote appropriate treatment for hypertension, we have added the **Controlling High Blood Pressure** measure to our Medicaid Quality Recognition, Model Practice, and Medical Home models.

AIM 3: EFFECTIVELY MANAGE MEDICAID PER CAPITA CARE COSTS

OUTCOME 1: Reduce Potentially Preventable Events
Associated measures:

• Potentially Preventable Readmissions	• Potentially Preventable ED Visits	• Follow-Up after ED Visits and Inpatient Admissions for BH

In addition to tying PCP performance metrics directly to **potentially preventable readmissions**, we will also incentivize BH providers for **Follow-Up After ED Visit for Mental Illness, Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence, and Follow-Up After Hospitalization for Mental Illness**.

Humana sees our Full Value VBP arrangements as a critically important tool for reducing PPEs. Through our extensive experience implementing full-risk arrangements in Florida, we have found that providers operating under the Full Value model have both the incentive and resources to ensure our Enrollees receive preventive care, including engagement of UTC Enrollees and attention to SDOH. By investing in integrated care and coordination with specialists (including BH providers), we see fewer admissions and ED visits and lower expenses.

k.iii.	Methods for evaluating the effectiveness of VBP, including tracking of costs and improvement in health outcomes.

We design our VBP programs to be flexible, measurable, and improvable. Using a variety of methods, we evaluate the effectiveness of our VBP programs and are always looking for ways to refine and enhance them. Our methods examine the data we collect from a few different perspectives, such as the financial impact on providers, as well as Enrollee health outcomes.

Financial Outcomes
Tracking costs and understanding whether providers are benefiting financially are essential steps to evaluate our VBP programs. One metric we use tracks the percentage of providers in value-based programs that earn shared savings. In 2017, for example, 70% of physician practices participating in Humana value-based programs earned shared savings, a 10% increase from 2016. This growth is encouraging and demonstrates that providers are engaging in their VBP arrangements and finding success.

Our program design ensures all costs associated with VBP incentives are offset by lower overall medical costs, as a result of fewer avoidable ED visits, hospitalizations, and other costly events. We compare the costs of patients who are attributed to physicians in Humana value-based agreements to those in FFS arrangements. In 2017, our analysis demonstrated that medical costs for patients attributed to physicians in Humana Medicare value-based arrangements were 15.6% lower compared to original Medicare FFS. Similarly, we examine the percentage of dollars spent on Enrollee care that PCPs receive. PCP practices in VBP arrangements with Humana received 16.8% of every dollar spent on Enrollee care in 2017, which is significantly higher than the national average of six percent (6%), as well as the six point nine percent (6.9%) that went to PCPs in non-VBP arrangements with Humana.

Improvement in Health Outcomes
As with our financial analyses, comparing data from providers participating in VBP arrangements against FFS data reveals valuable information about the effectiveness of our VBP programs. We examine a number of

metrics including hospital admission rates, ED visits, medication adherence, cancer screenings, and diabetes care. For example, patients in value-based care with Humana experienced 23.4% lower hospitalization rates than those in original Medicare FFS in 2017.

Our evaluations are based on the input of several teams within Humana and the results of clinical analytics to ensure we develop best-in-class programs. These include:

- Analytics and Forecasting: We have a VBP Analytics team dedicated to evaluating VBP results with the purpose of making sure we have the right program structure to influence behavior and health outcomes. The VBP Analytics team compares the results, including financial, quality, and health outcomes, of providers in VBP arrangements against results for providers in FFS contracting arrangements. They compare provider performance across different VBP programs and track trends of providers' movement between the programs. At a more detailed level, the VBP Analytics team assesses performance improvement across select measures to continually vet measure sets and associated benchmarks. They ensure VBP program incentives are recognizing providers for their work driving positive outcomes and not for randomly occurring events that would occur with or without a physician's intervention. These teams also help identify appropriate provider panel thresholds for different VBP programs, which can have a large impact on how performance is measured. They also inform the financial value of incentives by tracking costs and analyzing the value of closing gaps and meeting performance targets.
- Provider Experience team: Monitoring VBP trends across the industry is an important way of evaluating our own VBP programs. This team presents at healthcare association meetings and attends conferences, providing opportunities to learn and share ideas about value-based care across the country. Their findings help us see where our programs may fall short, as well as where they are successful, relative to what they see and hear at these functions.
- Medical Directors and the Office of the Chief Medical Officer: Our Medical Directors, as practicing physicians, provide a wealth of knowledge about the efficacy of our VBP programs. They provide clinical expertise as to which measures best apply to specific provider types based on what outcomes a specific provider type can impact. As physicians, they also provide insight about effective ways to interact with providers about VBP. Clinicians who participate on the Clinical Quality Metric Alignment Governance Committee, part of the Office of the Chief Medical Officer, also provide a valuable perspective as to whether the metrics in our VBP programs align with Humana's broader quality objectives.
- Market-Based Associates: Our network contracting teams, Provider Relations representatives, Provider Services Manager, Michelle Weikel, and Provider Network Director, Majid Ghavami, are locally based and serve as the front-line associates in VBP administration. These associates interact with providers, hear their concerns, support their successes, and help them identify ways to improve health outcomes and performance. They work together to identify whether performance targets are working and effective. They also evaluate the tools we use to communicate with providers about their performance and whether these reports convey enough actionable information in a clear and impactful manner. These teams have the necessary tools to analyze measurement results and assist providers in pinpointing appropriate interventions that will drive positive health outcomes.
- External Reviewers: We also value the input of external feedback and data, which is why we seek insights from independent reviewers, such as physician associations and healthcare organizations. These reviewers help us understand how our VBP programs perform against industry trends and help us identify specific areas for improvement.

I.	Provide results of any provider satisfaction survey reflecting the Vendor's performance in Kentucky or any other state Medicaid program over the last three (3) years. Where results identified provider dissatisfaction, Describe strategies the Vendor has implemented to address improvement, and examples of how those strategies have been effective.

Humana uses provider satisfaction surveys as a window into the effectiveness of our provider engagement strategy, as well as to identify specific steps to improve our providers' experience in various areas, such as our grievances and appeals process, claims submission, and provider outreach and training. Numerous teams, committees, and managers (including our Provider Services Lead, Mary Sanders, PAC, BH Subcommittee, and Provider 360 Committee) view and analyze survey results to monitor initiatives we put in place to improve areas of dissatisfaction among our providers.

The last three years of Kentucky Medicaid Provider Satisfaction Survey results are outlined in **Table I.C.9-11**. Through these surveys, we have observed many instances where 90% of providers rated Humana as above average or average. Such instances include provider opinion about access to knowledgeable UM staff and CMs and the timeliness of obtaining pre-certification, referral, or authorization information. Many other types of questions were asked in the provider surveys including practice profile questions and questions about the types of information providers like to receive when receiving a referral. For our complete Kentucky Medicaid Provider Survey results, please see **Attachment I.C.9-5 2017-2019 Provider Satisfaction Survey Results**.

Table I.C.9-11: Humana-CareSource Kentucky Medicaid Provider Satisfaction Survey Results, 2017 to 2019

Humana-CareSource Provider Survey Question	2017			2018			2019		
	Sample Size (n)	Average	Above Average	Sample Size (n)	Average	Above Average	Sample Size (n)	Average	Above Average
Access to knowledgeable UM staff	431	58.7%	33.2%	197	62.4%	31.0%	353	58.1%	33.1%
Procedures for obtaining pre-certification, referral, or authorization information	413	61.0%	31.2%	196	66.8%	25.0%	355	58.9%	32.4%
Timeliness of obtaining pre-certification, referral, or authorization information	417	59.7%	32.1%	192	68.2%	25.5%	350	58.6%	33.2%
Facilitation and support of electronic PA system (in the Humana-CareSource Provider Portal)	337	64.4%	28.8%	162	68.5%	25.9%	288	62.5%	29.2%
Access to knowledgeable CMs	392	64.8%	27.3%	186	72.6%	22.0%	333	63.7%	28.2%

Table I.C.9-11: Humana-CareSource Kentucky Medicaid Provider Satisfaction Survey Results, 2017 to 2019

Humana-CareSource Provider Survey Question	2017			2018			2019		
	Sample Size (n)	Average	Above Average	Sample Size (n)	Average	Above Average	Sample Size (n)	Average	Above Average
Degree to which Humana-CareSource covers and encourages preventive care and wellness	377	58.1%	35.8%	183	63.4%	33.3%	335	57.0%	33.4%
The number of specialists in provider network	301	67.1%	20.9%	159	73.6%	17.0%	277	65.7%	21.3%
Quality of specialists in their provider network	299	68.2%	24.8%	155	68.4%	24.5%	279	64.2%	28.6%

Through provider satisfaction surveys in our other Medicaid markets, we have learned that providers are extremely satisfied with the knowledge of our clinical management support, the professionalism of our Provider Relations representatives, and the ease of submitting claims electronically, each earning a satisfaction rating of 99%. We have provided results of the last three available years of the provider satisfaction surveys from our Florida MMC program in **Table I.C.9-12** to further illustrate our commitment to providing appropriate support and tools to our provider partners.

Table I.C.9-12: Florida Medicaid Provider Satisfaction Survey Results, 2016 to 2018

All table results reflect answers of either "Strongly Agree" or "Agree"	2016		2017		2018	
	# of Responses	% of Total	# of Responses	% of Total	# of Responses	% of Total
My Provider Relations representative is: Knowledgeable	39	83%	66	97%	79	91%
My Provider Relations representative is: Able to answer my questions	39	85%	67	99%	77	92%
My Provider Relations representative is: Responsive to my needs or concerns in a timely manner	36	80%	66	97%	73	86%
My Provider Relations representative is: Professional and courteous	40	91%	66	99%	86	99%
Educational and training materials are easy to understand	38	84%	61	98%	78	96%
In the last 12 months: I participated in an in-office visit from a Humana representative	26	54%	42	72%	61	73%
I am routinely updated on: New policies and processes that impact my practice	35	73%	60	94%	71	83%

Table I.C.9-12: Florida Medicaid Provider Satisfaction Survey Results, 2016 to 2018

All table results reflect answers of either "Strongly Agree" or "Agree"	2016		2017		2018	
	# of Responses	% of Total	# of Responses	% of Total	# of Responses	% of Total
I am routinely updated on: Regulatory changes that impact how my practice and Humana conduct business [e.g., AHCA, Health Insurance Portability and Accountability Act (HIPAA), etc.]	34	77%	60	91%	68	82%
I am satisfied with the amount of time it takes to obtain a referral/authorization	38	88%	61	91%	64	80%
I am satisfied with the ease of the review process for utilization or case management	34	83%	63	93%	66	84%
Medical necessity review is provided in a timely manner	37	86%	63	98%	74	91%
Denial notifications, including the denial reason(s), are provided in a timely manner	34	79%	67	100%	69	91%
I am satisfied with the ease of submitting claims electronically	34	92%	62	98%	75	99%
Claims are processed and paid in a timely manner	30	81%	56	97%	63	88%
I am satisfied with the accuracy of claims processing	26	70%	57	95%	58	79%
Claims payment problems or disputes are handled easily	22	59%	48	87%	49	71%
I have filed a complaint/grievance or appeal and found the process easy to follow	21	64%	21	75%	35	65%
The provider grievance process is effective	23	74%	22	76%	45	75%
Overall, I am satisfied with the provider complaint, grievances, and appeals process	24	75%	23	77%	44	72%
When filing a complaint, the complaint was addressed in a prompt manner	25	81%	22	81%	40	71%
My complaint was resolved without having to make multiple inquiries	16	55%	19	68%	31	54%
Case managers are knowledgeable, professional, and courteous	35	92%	44	100%	66	99%
Case managers involve the physician in the Enrollee's care	34	89%	41	95%	61	92%
I am satisfied with the clinical support provided by the Case managers	34	89%	41	95%	63	95%
Overall, I am satisfied with the Humana Medicaid product	33	80%	43	88%	72	81%
Overall, Humana Medicaid is the easiest insurance carrier with which to do business	25	61%	35	78%	47	59%

STRATEGIES TO ADDRESS IMPROVEMENTS IN PROVIDER SATISFACTION

Humana has made several process improvements as a result of our overall analysis of our provider satisfaction surveys. For example, we are beginning a Gold Carding pilot program for our Florida Medicaid providers that waives PA requirements for those who have consistently exceeded PA performance and quality criteria. We will expand this Gold Carding pilot program to include Kentucky providers, tailoring it to their specific needs. Additionally, we have implemented a Live Line for providers to access and request information about claims from associates in our Provider Program Integrity unit and made improvements to Availity to bolster self-service options. **Table I.C.9-13** describes other specific actions to improve provider satisfaction in our Kentucky Medicaid and additional markets, as a result of our provider satisfaction surveys.

Table I.C.9-13: Initiatives to Improve Provider Satisfaction

Disagree/Strongly Disagree Responses	Solutions Identified
8.2% of Kentucky Medicaid providers surveyed in 2018 rated Humana as below average on "the procedures for obtaining pre-certification, referral, or authorization information."	Humana will ensure that our providers have after-hours access to our provider portal, Availity, to submit authorization requests and access Enrollees' enrollment information, claims status, and authorizations.
35% of Florida Medicaid providers surveyed in 2018 disagreed/strongly disagreed that "I have filed a complaint/grievance or appeal and found the process easy to follow."	For provider non-claims-related complaints, we updated our Provider Training Manual to include details and instructions to streamline the process for providers submitting a complaint.
25% of Florida Medicaid providers surveyed in 2018 disagreed/strongly disagreed that "the provider grievance process is effective."	We took several steps to redress this finding including: • Updating our communications regarding the process for filing provider grievances in the Enrollee Handbook and Provider Manual • Establishing a dedicated team to handle provider calls • Creating a dedicated team to address all non-claims-related complaints to assist in resolution turnaround time • Investing in an Issue Management System (IMS) to support the Cost Claims Management's Issue Resolution team to manage provider inquiries, manage caseloads and inventory, and create a "business-friendly" environment for providers.