

**C. Technical Approach**

**10. Utilization Management (Section 20.0 Utilization Management)**

**a.** Describe strategies the Vendor will implement to identify and reduce inappropriate utilization of services, including emergency departments. Address the following at a minimum:

**a.i.** Proposed approach to using data to inform the Vendor’s efforts to improve appropriate use of service and cost efficiencies, as well as to identify potential Fraud and Abuse referrals.

Humana’s Utilization Management (UM) program, led by our UM Director, Kathy Kauffmann, directs Enrollees to the highest quality and most appropriate level and type of care in a timely manner – an approach that ensures Enrollees receive medically necessary care in the appropriate setting. Because our UM program ultimately reports through our Quality Improvement Committee (QIC), a strong link exists between utilization and improving quality of care. Our UM program uses innovative data analytics systems to monitor utilization and ensure Enrollees receive the right care, at the right place, at the right time. Our approach to using UM data stems from established quality improvement (QI) tenets. We rely heavily on data-driven activities that result in identifying barriers, root causes, and systemic problems that would otherwise lead to fragmented service delivery. Humana has developed strategies to use utilization data and metrics to manage the care of our Enrollees more effectively, while maintaining focus on efficient service delivery.

**INTEGRATED CLINICAL PLATFORM**

Humana’s integrated clinical platform, Clinical Guidance eXchange (CGX), is key to the success of our UM program. This system creates a complete holistic view of the Enrollee, enabling our UM and care management teams to manage care in real time regardless of the care setting. CGX captures and houses Enrollees’ enrollment data, service authorizations [both medical and behavioral health (BH)], care management, pharmacy, laboratory, and other data. Key to our external-facing information systems is our innovative CareHub Clinical Technology platform, which serves as the integration point between our electronic care management system, external providers, and other organizations. Designed to share digitally and aggregate actionable data across multiple systems, providers, community service organizations, and other relevant parties, this system enables our UM team to obtain supplemental information critical to reviewing and approving service requests and to communicate prior authorization (PA) information to providers in real time. We have illustrated our integrated system and its components in **Figure I.C.10-1**.



## **MONITORING FOR APPROPRIATE AND INAPPROPRIATE USE OF SERVICES**

Ensuring that our Enrollees receive the right care, at the right place, at the right time is at the forefront of our UM program. We have established robust data analytics systems and logic-driven processes to monitor, identify, and respond to both underutilization and overutilization patterns. Our data systems provide a platform to proactively monitor for overutilization or underutilization of services and identify outliers in data that may indicate a utilization or quality of care issue. This process identifies potential inconsistencies in service utilization by comparing the approved services with identified Enrollee needs documented in the plan against utilization parameters. **Since Humana's Kentucky operations include full integration of physical, BH, and pharmacy benefit management (PBM)** data, we can analyze the full array of utilization across our Enrollee populations. Humana reviews frequency of selected procedures, BH services, emergency department (ED) visits, pharmacy and inpatient measures, and Healthcare Effectiveness Data and Information Set (HEDIS) gaps in care as relevant monitors for over- and underutilization management trends. We select and monitor utilization indicators to detect inappropriate utilization trends, including but not limited to, the following:

- Acute admits per 1,000 Enrollees
- Inpatient days per 1,000 Enrollees
- BH inpatient admissions per 1,000 Enrollees
- Rehabilitation admits per 1,000 Enrollees
- Skilled Nursing Facility (SNF) average length of stay
- Readmission rates within 7, 14, and 30 days
- ED visits per 1,000 Enrollees
- Observation rate
- Post-Discharge care coordination referral calls
- 3M potentially preventable events (PPE) metrics
- Use of opioids at high dosage
- Use of opioids from multiple providers

We produce **operational dashboard reports** that aggregate data in an actionable format to help identify Enrollees who are at high risk for preventable high-cost utilizations or overutilization of services. The UM committee evaluates these reports monthly. The reports include those listed in **Table I.C.10-1**.

**Table I.C.10-1: Operational Dashboard Reports**

Report	Description
<b>Inpatient Census Report</b>	Daily detailed account of acute and sub-acute inpatient facility admission cases
<b>3M PPE Report</b>	Identifies admissions, readmissions, facility-based complications, ED visits, and ancillary services that likely could have been prevented
<b>Inpatient Clinical Dashboard</b>	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
<b>Early Indicator Report (EIR)</b>	Monthly reporting of key utilization metrics, such as admits/1,000 by utilization type [Acute, SNF, Rehab, Long Term Acute Care Hospital (LTACH)], inpatient days/1,000, length of service by type, ED visits/1,000, etc. Dashboard format allows user drilldown for analysis by demographics, such as geographic region, plan type, and age of user
<b>High Utilizer Report</b>	Monthly report allowing us to drill down into individual Enrollees with high utilization by service type, e.g., ED, inpatient care, etc.
<b>Provider Utilization Profiling</b>	Quarterly provider-level report of claims and encounter data to analyze under- and overutilization and to provide peer-to-peer analysis
<b>Predictive Model Reporting</b>	<b>Predictive model for Severity Score</b> , updated monthly, and <b>Inpatient and Readmission Model</b> , updated daily from admission to discharge are integrated into our clinical platform, CGX, to trigger referrals for clinical programs; <b>ED Predictive Model</b> scores available by report each month and are integrated into CGX; <b>Opioid Predictive Model</b> to identify high-risk Enrollees
<b>Readmissions by Provider</b>	Monthly tracking of 14- and 30-day readmission rate for acute admissions and physician visit within 14 days of discharge date
<b>Provider Payment Integrity Report</b>	Monthly tracking and dashboard related to provider payment outlier analysis and trending and analysis to identify potential fraud, waste, and abuse (FWA)
<b>High utilizer/High-cost Prescription Report</b>	Report identifies Enrollees who have 10 or more unique drugs that average more than \$250 per prescription
<b>Pharmacy all claims detail</b>	Report provides Enrollee, prescriber, and pharmacy claims detail for all pharmacy claims processed within the selected time period

Our utilization reporting is also a key component of our care management continuum to identify specific Enrollee needs and to identify gaps in care. With these data, our Care Managers (CM) can direct Enrollees to the most appropriate care setting.

**IMPROVING OUR COST EFFICIENCIES**

Humana is committed to ensuring outcomes-based, cost-effective care of individual Enrollees based on their current clinical situation and the support systems available. The UM team regularly reviews our array of UM reporting to monitor trends and identify over- and underutilization. Data are aggregated from across our operations, including clinical utilization reviews, aggregate claims, encounter and authorization data, and

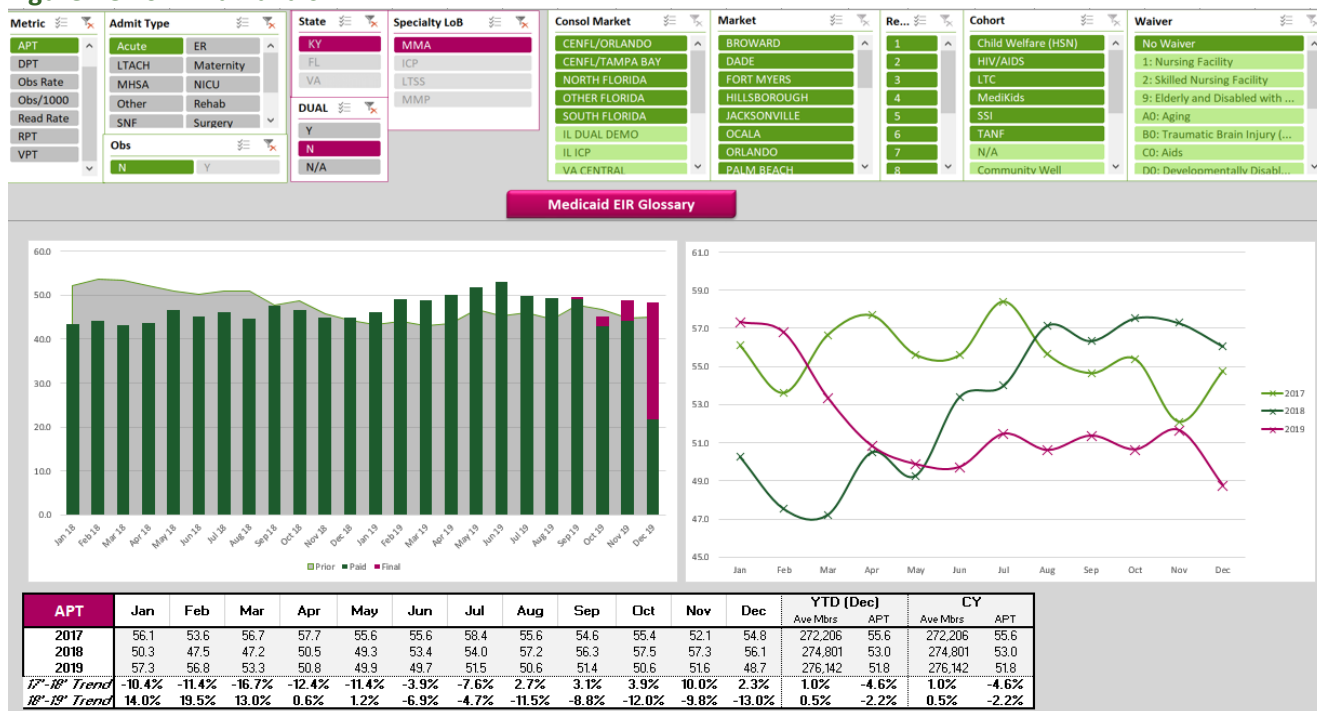
provider communications. The UM department develops indicators for identifying potentially inappropriate over- and underutilization; the UM and Quality Improvement Committees evaluate the results.

### Early Indicator Reporting (EIR)

We have a well-defined monthly process of monitoring emerging utilization patterns. Humana’s sophisticated **EIR suite** uses the latest authorization and claims data and allows our clinical UM associates to evaluate utilization and identify opportunities, outliers, and trends. This interactive, user-friendly dashboard is built primarily from claims data with actuarial completion principles, allowing earlier recognition of key population trends, such as an increase in ED utilization. With the EIR, users, including UM leaders, can see overall performance at a glance and drill down to specific data elements to analyze data quickly and identify root causes. The EIR also includes front-end review metrics where we monitor appropriate inpatient versus observation utilization. This report provides month-to-month and year-over-year trends. This information is shared in a monthly meeting including market leadership, Clinical, Provider Network, Finance, and Actuarial teams.

Below is a sample of our reporting suite (numbers do not reflect actual experience).

Figure I.C.10-2: Humana’s EIR



### Humana’s Medicaid Trend Team

The Humana Medicaid Trend team identifies and analyzes utilization and cost trends across our Medicaid programs. The Medicaid trend process occurs monthly and encompasses leadership from Provider Network, Clinical, Financial, Operational, and Actuarial teams who meet to review and evaluate trend results across all Medicaid lines of business. This collaborative process promotes the sharing of best practices to address identified issues across our Medicaid plans. The Medicaid Trend team finds opportunities to lower inappropriate utilization, unit cost, or cost 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

The goal of trend meetings is **to explore outlier cost and utilization trends as well as potentially fraudulent or wasteful events** to determine if we can and should implement mitigating initiatives to create efficiencies. 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. The Medicaid Trend team calculates and tracks initiative savings and includes financial projections for 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; presenting at the Medicaid Trend committee regularly as needed
- Forecasting long-term trends and providing input into budget and rate adequacy processes
- Identifying emerging trends in data, assessing for potential trend-bender opportunities, and presenting to Medicaid Trend committee
- Monitoring PPEs and incorporating into all of the above
- Conducting ad hoc analyses for key stakeholders as needed

#### **Kentucky ED Diversion Initiative – Enrollee Outreach Calls to Super Utilizers**

Through analysis of claims and encounter data, we found that ED high utilizers as a percent of total Enrollees increased between the second half of 2017 and the first half of 2018 in our Kentucky Medicaid Managed Care (MMC) program. We define ED high utilizers as an Enrollee with four or more ED visits in a six-month time period. For those Enrollees whom we identified, we conducted the following interventions:

- Phone call outreach, which included:
  - Education was provided regarding the appropriate places and times to obtain healthcare
  - Assistance was provided locating a Primary Care Provider (PCP) and/or scheduling an appointment
  - Assistance was provided to overcome barriers such as transportation
  - Referrals were made to care management as appropriate
- Enrollee ED Diversion/Medical Advice Line Letter mailed to identified ED high utilizers
- After hours brochure shared with providers and mailed to targeted Enrollees

As a result of our Enrollee outreach, the percentage of **ED high utilizers decreased from 2.36% in the first half of 2018 to 2.17% in the second half and to 1.86% in the first half of 2019**. Service Regions 4 and 6 also showed a **shift of 4.3% and 4.0%, respectively, to urgent care visits** during this time, while Service Region 5 showed a **2.5% shift to rural health clinics**, indicating that our Enrollees were seeking services in a more appropriate care setting.

#### **IDENTIFYING AND REFERRING FWA**

Humana understands the importance of identifying FWA, and we train our associates annually on how to identify FWA and the mechanisms through which they can report suspected cases. We perform data mining to search for unusual or unlikely situations. Examples of cases and trends Humana typically looks for include, but are not limited to:

- Non-participating providers billing a high percentage of claims
- Providers with a high percentage of split billing
- Same diagnosis codes used with multiple patients
- Number of patients seen in a day

- Enrollees receiving three different narcotics from three different providers from three different pharmacies
- Number of Enrollees receiving more than three scripts per visit
- Providers billing 85% or more claims with the same Current Procedural Terminology (CPT) code
- Enrollees between 25 and 50 miles away from the pharmacy
- Providers billing with a skewed proportion of number of claims to dollar value of claims
- Percentage of drug sales skewed to a region
- Large percentage of high-cost drugs

If through our analysis of UM data, we find instances of suspected fraudulent or inappropriate utilization on the part of the Enrollee or provider, we refer those cases to the Special Investigations Unit (SIU). Humana's SIU is responsible for the detection, prevention, and investigation of health and dental insurance FWA. Humana's SIU comprises associates with various backgrounds including data analytics, clinical credentials, and investigational training.

In an effort to promote proper business practices and preserve reasonable premium rates, SIU associates investigate and work with appropriate law enforcement agencies when dealing with insurance FWA by providers, Enrollees, agents, employer groups, company associates, and other individuals. Our UM associates can refer to SIU either telephonically or via email. Humana's SIU conducts reviews of clinical data to inform potential FWA cases. The SIU uses the CGX platform to search and view medical pre-authorization data, searching by authorization number and Enrollee identification. Once SIU locates an authorization, the system provides authorization dates, approval status, relevant nurse documentation of the clinical timeline, and nurse phone call logs.

In 2019, SIU investigated 249 cases related to our Kentucky Medicaid program.

Humana addresses any potential problems regarding utilization, including potential cases of fraud and abuse, immediately, forwarding them to Humana's Cost Claims Management (CCM) department, Humana's overarching department responsible for carrying out our FWA efforts. CCM has a Shared Services team with cross-functional responsibilities, such as the CCM Compliance team, as well as sub-units that have their own area of expertise including clinical audits, investigations, and complex data analysis.

We train new associates on investigation techniques and processes to complete cases, including national and industry-related FWA trend training. Humana trains all associates on the submission of FWA allegations. The triage area handles all allegations referred to SIU to verify if the allegation has merit for investigation.

### Using Data to Address Inappropriate Utilization and Improve Appropriate Use of Services

Humana's comprehensive UM program has policies in place to both respond immediately to specifically identified utilization problems and to implement strategies to improve utilization patterns in the long term.

- In the short term: The clinical team receives daily census reports on inpatient utilization. The team works collaboratively with the care team [including hospital discharge planners, the Enrollee's multidisciplinary team (MDT), and any specialists involved in the care] during the entire hospitalization to close gaps in care and connect the Enrollee back to their PCP.
- In the mid-term: We proactively monitor utilization trends to assess the population health of our Enrollees as well as to identify gaps in care and areas for quality improvement. We schedule regular meetings with the clinical team to discuss Enrollees who require complex medical management, BH interventions, and discharge coordination and who may also have social determinants of health (SDOH) barriers. The team discusses Enrollee utilization patterns and current clinical needs, including physical capabilities, family structure and support system, and BH concerns. They also discuss potential problems they have identified, using analysis of utilization patterns, with the PCP. For example, we provide daily ED visit reports to our engaged providers so they can conduct follow up with their Enrollees who accessed the ED.

Currently in Kentucky, we review admission data with providers and through UM rounds, monitor for outliers in admissions, average length of stay, and readmissions.

We also analyze utilization data and produce a series of internal reports that monitor utilization at the population and Enrollee levels. We use utilization data as an important part of our care management continuum to identify specific Enrollee needs and to identify gaps in care. With these data, our CMs can direct Enrollees to the most appropriate care setting. Our Enrollees have access to our 24 hours a day, seven days a week Medical advice line to assist in determining the appropriate level of care. For our higher-need and more frequent utilizer Enrollees, we refer to case management for assistance in coordinating the appropriate services.

- **In the long term:** Our comprehensive data warehouse and targeted data-marts provide value-added views of data, which allow us to recommend and measure strategic and targeted improvement projects. Once we identify potential problems related to overutilization, we solicit input from providers, hospitals, and provider-based staff to generate feedback on utilization trends. The goal is to identify risk factors and facilitate the development of innovative management and treatment alternatives, including specific medical management, BH management, physical health management and coordination, and community-based programs.

**Humana brings the ability to use our robust data analytics resources to roll out initiatives across multiple lines of business.** Our decades of experience with Medicaid, Medicare, and Commercial populations has allowed us to hone our ability to effectively take utilization data and make substantive changes that truly affect health outcomes. We pride ourselves on our scalability, and we have brought this strength to the Kentucky MMC program. If, based on our analysis of the Kentucky population, we identify an initiative from one of our other existing lines of business (Medicare, Commercial, or Dual Eligibles) that we believe will drive measurable improvement in the health of Kentucky Medicaid Enrollees, we have the capabilities and resources to quickly and efficiently implement such an initiative.

**a.ii.**

Overview of the Vendor’s methods for monitoring appropriate health care utilization, including two examples of identified negative trends, initiatives undertaken to improve them, and the results of these initiatives.

Humana’s UM program relies upon established UM processes, such as PA, concurrent reviews, and retrospective reviews, to monitor appropriate healthcare utilization. Within these processes, we have developed various methods for ensuring our Enrollees access the most appropriate services based on their clinical needs and social circumstances. We outline these methods below, followed by two examples of how we have addressed negative UM trends.

**PRE-SERVICE REVIEW PROCESSES**

**Prior Authorization**

The overarching goal of Humana’s UM program is to ensure our Enrollees receive the right care, at the right place, at the right time. Our service authorization processes are rooted in this goal, understanding that the Enrollee’s best interest is at the heart of each service determination. We have included the flow chart depicting our authorization processes in **Figure I.C.10-3**.

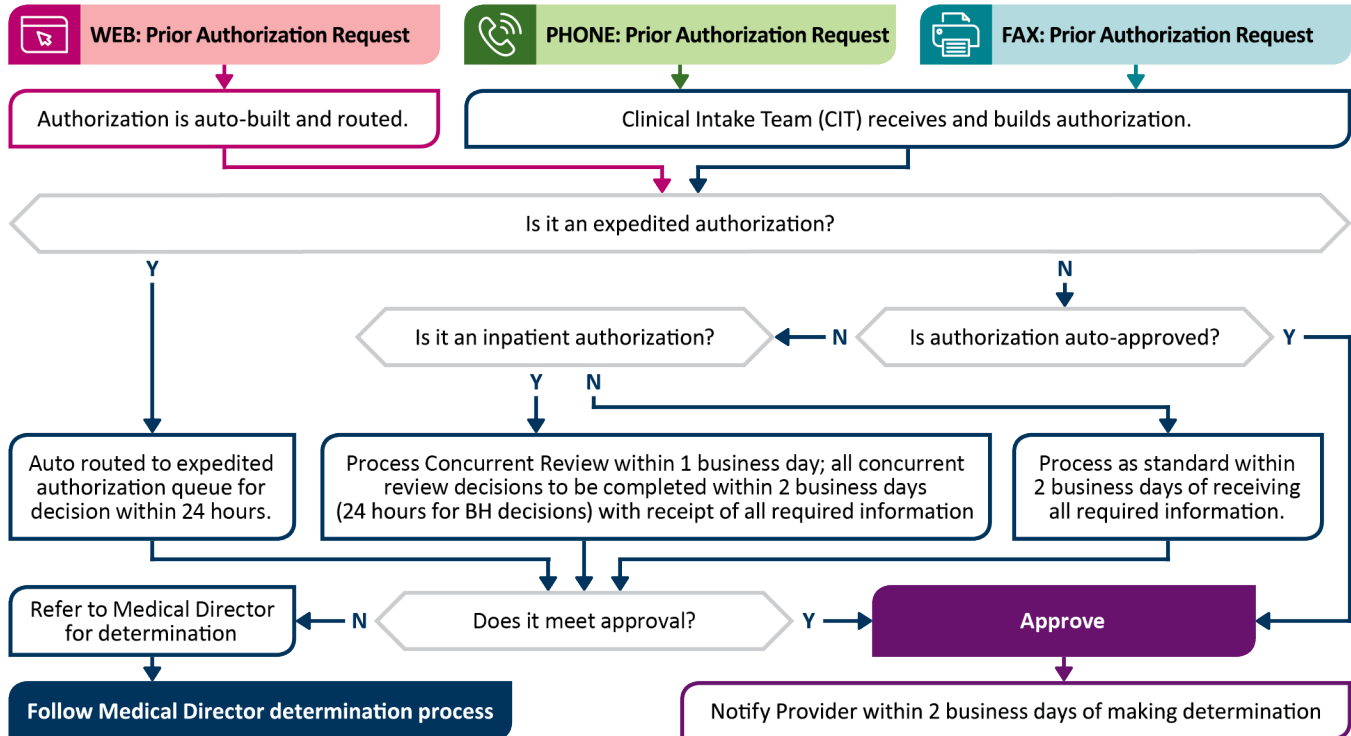
The Enrollee, their PCP, or their treating physician can initiate a request for services 24 hours a day, seven days a week. Enrollees may submit a written request for services or they can call our Clinical Intake Team (CIT) to start the authorization request. We offer providers several methods of submitting and obtaining an authorization:

- Electronically via our provider portal at Availty.com
- Fax
- Telephonically, including Interactive Voice Response (IVR)

For providers who would like a more hands-on approach to service authorizations, the **Kentucky-based CIT** will be the primary point of entry for telephonic, fax, and paper authorizations requests for Kentucky Medicaid. The

team is supported by a single phone system and operating policies, procedures, and workflows. The CIT provides non-clinical staffing for the intake of authorization requests made via electronic submission via Availity.com, phone or fax and makes requests for supporting clinical information, if necessary.

Figure I.C.10-3: Humana’s Automated Prior Authorization Processes



### Preadmission Screening

To reduce potentially preventable readmissions, Humana will conduct **outreach to 100% of planned, non-emergent admissions** to ensure our Kentucky Medicaid Enrollees have the supports in place when they return home. When we receive and approve an authorization request for a non-emergent admission, our UM/Transition Coordinators (TC) reach out to the Enrollee for a preadmission screening during which we:

- Educate Enrollees on what to expect during and after the hospitalization/procedure
- Identify and authorize any medically necessary durable medical equipment (DME) the Enrollee may need post-discharge
- Identify any SDOH needs and connect the Enrollee with the Humana SDOH coordinator to identify available community resources
- Identify and authorize any post-discharge services, such as home health or rehabilitation
- Educate Enrollees on our care management program if applicable
- Schedule transportation to home or post-discharge services, if necessary

Because our UM/Transition Coordinators are part of our Comprehensive Care Support (CCS) team, we capture all preadmission screening information in our integrated clinical platform, CGX, which all Humana CCS associates can see, including medical and BH information. CGX can issue tasks and reminders to our associates indicating post-discharge needs and follow up.

### Front-End Review

Humana UM, led by our UM Director Kathy Kauffmann, performs real-time reviews of medical necessity criteria for inpatient admissions to divert potentially preventable admissions to a lower level of care when appropriate. When an Enrollee presents to the ED, and as a result, an authorization for an inpatient admission is submitted to Humana, our UM team conducts a review of the available clinical information to determination medical



necessity and the appropriate level of care. For BH inpatient stays, the provider completes a MCG-based questionnaire through our provider portal, Availity, or over the phone with the CIT. If the request meets guidelines and parameters for approval, our Kentucky-based BH UM team authorizes the request for up to seven days; an additional review is conducted at the end of that seven day period. We work with hospital staff on obtaining detailed clinical information related to an admission request and either approve an inpatient admission or appropriate lower level of care (e.g., observation or outpatient follow up). If an Enrollee's condition changes while in observation and an inpatient order is received, the UM team will review the clinical information submitted by the facility for medical necessity and appropriate level of care.

Following the admission, the UM team performs discharge planning to ensure the Enrollee is scheduled for a follow-up visit with their PCP following discharge and to ensure post-discharge support for the Enrollee is in place.

### **CONCURRENT REVIEW PROCESSES**

#### **Concurrent Review**

We perform concurrent reviews on all ongoing inpatient stays to ensure our Enrollees receive the most appropriate care in the most appropriate setting. Our concurrent review processes include:

- Clinical utilization review to ensure coordination of inpatient services as ordered, specialist provider referrals within the network, and prevention of duplication of services already performed in the outpatient setting
- Coordination of discharge services including utilization review for appropriate discharge to skilled, long-term acute care, acute rehabilitation levels of care, BH intensive outpatient, and/or BH partial hospitalizations
- Referral for care management, management of chronic conditions, and social services (including SDOH needs) based on Enrollee's identified needs. Communicate and provide updates to MDT for transition of care to the outpatient setting
- Coordination and communication with the hospital team and outpatient providers on Enrollee's care plan
- Enrollee and family education on disease processes and available services

#### **UM Rounds**

As a part of our ongoing concurrent reviews, Humana holds UM rounds, led by the CM, for their Enrollees in care management in which the UM/Transition Coordinator and CMs review the cases of Humana Enrollees currently admitted to a facility. Rounds occur twice a week or more frequently as needed. During these rounds, the Humana team reviews both physical health and BH cases while the CMs help to identify Enrollee discharge needs, including SDOH needs. Based upon the needs of the Enrollees, referrals are made to the appropriate resources and PAs are entered that may be needed prior to discharge. Our UM/Transition Coordinators and CMs communicate as frequently as necessary outside these UM rounds to ensure a safe and comprehensive discharge plan is in place.

### Humana Onsite Nurse Liaison Program

In Kentucky, **we will place UM nurses onsite in high-volume facilities, including BH facilities**, (with facility permission) to provide face-to-face discharge planning. The Humana Onsite Nurse Liaison program seeks to facilitate:

- Personalized Enrollee experiences with face-to-face engagement to assess individual Enrollee needs from a holistic approach
- Individualized assessments to identify gaps in care and SDOH needs
- Real time Enrollee intervention and coordination of services; onsite nurses can proactively anticipate and plan individual Enrollee needs and coordinate services to ensure a successful transition of care from the inpatient setting
- A collaborative approach of care and Enrollee engagement involving the onsite nurse liaison, PCP, hospitalist, Humana CCS team and hospital team
- Improved provider relationships and engagement amongst multidisciplinary teams to meet individual Enrollee needs

“  
My office is very pleased to have the Humana Nurse Liaison on our team. Being she is onsite at the hospital, we can trust without a doubt that our Enrollees are taken care of and are receiving the quality of care they deserve.

”  
– Royal Palm Medical Center,  
Royal Palm Beach, FL

Our onsite Nurse Liaisons will work with our UM/Transition Coordinators, our BH UM associates, and the CCS team (including the CM, SDOH coordinator, community health workers (CHW), and housing specialists) to facilitate a smooth discharge and transition back into the community.

### Post-Discharge Outreach

Our discharge planning activities begin upon the Enrollee’s admission and focus on identifying and addressing gaps in care to prevent readmissions. We collaborate with the facility, participate in discharge planning, and ensure the Enrollee has access to their MDT to assure we meet all needs when discharged. We also reach out to all Enrollees post-discharge, basing the specific outreach on the Enrollee’s risk level, as determined by their Readmission Predictive Model (RPM) score. The RPM uses inputs from more than 50 variables, including demographics, previous medical and pharmacy claims, previous admissions, days since last admission, medications, and information about their current admission. The process generates a numerical RPM score, which allows us to stratify and prioritize care.

- Complex/high-risk and medium-risk Enrollees: Route directly to a CM for post-discharge outreach. The CM administers a post-discharge survey/screening tool, which identifies gaps in care and documents interventions to close those gaps, and identifies Enrollees eligible for Humana Population Health Management (PHM) programs. We will also route Enrollees already participating in population health management to their assigned CM, if applicable, to update the care plan if a change in condition occurred. We consider all discharges from a BH facility to be high risk, and these Enrollees will always receive a live call to discuss post-discharge needs.
- Low-risk Enrollees: Receive an automated voice activated technology (VAT) call explaining Humana’s post-discharge services. We route Enrollees who request follow up to a CM for the post-discharge screening.

### Enrollee Story: Humana Concurrent Review

A complex, critically ill, ventilator-dependent Medicaid Enrollee was admitted to an acute facility under another payer and became active with Humana after several months in the hospital.

The **Humana UM nurse worked with the Humana social worker** coordinating benefits, services, and care and spoke with the Enrollee's daughters almost daily to assist with ensuring the Enrollee's wishes could be met in the home.

The UM nurse **worked with the hospital nurse manager** to ensure the staff trained the family on suctioning/bolus feeding and general day-to-day care. The Humana social services worker and UM nurse collaborated with the home care vendor daily to ensure supplies were delivered in preparation for discharge. The UM nurse also **worked closely with our respiratory supply vendor** to provide a vent, suction, and back-up vent with extended battery life.

The UM nurse **provided periodic updates to the PCP** and **acted as the centralized contact** in the coordination of services and communication between vendors and was instrumental in ensuring the family was educated and ready to take on this care for their loved one. As a result of the UM nurse's efforts, this complex Enrollee successfully stayed home without a readmission for more than six months.

## MONITORING HIGH-RISK/HIGH-COST SERVICES

### Emergency Department Utilization

Identifying High ED Utilization: Humana's processes for identifying high ED utilization feature robust Information Technology (IT) infrastructure and reporting capabilities used alongside our Enrollee-centered care management programs. Our processes begin with sophisticated tools to identify Enrollees at risk for high ED utilization. Our proprietary ED Predictive Model quantifies the likelihood of future ED utilization for each Enrollee. The model creates a profile of each individual, which includes cost and utilization for different clinical, behavioral, and functional conditions as well as socioeconomic profiles. It enables Humana to identify and target high-risk Enrollees for clinical interventions that reduce avoidable ED visits, which fosters the following benefits:

- Opportunities for proactive Enrollee engagement and education to mitigate barriers to optimal health management
- Referrals to clinical programs and alignment with support services
- Prevention of repeated ED visits as a substitute for primary care (often detrimental to Enrollees with chronic conditions), creating a stronger patient-provider care partnership

Our **High-Utilizer Report** (HUR) monitors and tracks ED utilization at the Enrollee level, identifying Enrollees who have disproportionately high ED utilization and are considered "ED frequent fliers." We use this report to identify high-risk Enrollees needing care management outreach to address outstanding medical, behavioral, or SDOH needs. Additionally, key utilization indicators are included in Humana's sophisticated **EIR**. We produce this user-friendly dashboard primarily from claims data with actuarial completion principles to incorporate data from the authorization system, allowing earlier recognition of key population trends, such as an increase in ED utilization. With the EIR, users can see overall performance at a glance and drill down to specific data elements to quickly analyze data and identify root causes. This report allows analysis of month-to-month and year-over-year trends.

Addressing High ED Utilization: Once we have identified high ED utilization either at the individual Enrollee level or as a population-level trend in certain regions, we use our Enrollee-centered clinical and care management protocols to identify the cause of the increased utilization and to develop strategies to address the underlying issues. When we identify an Enrollee who is at risk for or has had high ED utilization via the tools above, we try to engage that Enrollee in care management. **Care management** is one of our frontline defenses to reducing ED utilization. Through regular interactions with Enrollees, their PCP, and other community resources as needed, our CMs can often prevent avoidable or non-urgent ED visits and can assist the Enrollee in accessing care through PCPs, urgent care, or other outpatient services, such as home health. Once an Enrollee has visited the ED, CMs can evaluate any new or evolving care needs and ensure Enrollees have the supports (medical, BH, and social) to access care in the most appropriate setting. We also offer **Enrollee incentives for accessing care in the most appropriate setting** in the form of gift cards, either for preventive care or for completion of appropriate level of care training (where Enrollees learn for which conditions they should visit primary care, urgent care, and the ED).

Humana intends to provide extensive in-home services for Medicaid Enrollees with high-need, high-cost conditions and frequent ED utilizers in an effort to prevent avoidable ED utilization. We offer a **BH Crisis Line** to help our Enrollees navigate immediate BH-related conditions. Enrollees who contact either the BH Crisis Line or the Medical advice line will receive a follow-up contact the following day from our clinical team to assure all needs have been met and coordinate care with the PCP and/or specialists. The follow-up call will help avoid ED visits and avoidable admissions through addressing care gaps and/or SDOH needs.

Humana Enrollees with high ED utilization are considered “super-utilizers” and can receive **in-person visits** with our CMs and their PCP to identify barriers to appropriate utilization.

We train our CMs to educate Enrollees and caregivers on how to contact our Medical advice line 24 hours a day, seven days a week in the event of a non-life-threatening situation. Once connected, the Medical advice line will assess the Enrollee to determine if their symptoms can be treated with in-home urgent care as opposed to an ED visit. If so, the Medical advice line will connect the Enrollee to our virtual **in-home urgent care solution, MDLIVE**. This telehealth solution connects our Enrollees to providers via a smartphone application, the Internet, or a phone to provide an alternative to an ED visit.

Through our provider engagement model and our connectivity to Admissions, Discharge and Transfer data, as well as claims, **we deliver ED reports to our network PCPs, notifying them that one of their Humana Enrollees visited the ED**. This information allows our PCPs to perform outreach quickly to our Enrollees following an ED visit to engage them in primary care. Our Provider Engagement Model allows us to work directly with our provider groups to track, monitor, and analyze ED utilization. Our provider-facing Quality Improvement Advisors (QIA) work with our providers to identify areas for improvement and develop strategies to reduce potentially preventable ED visits. We will conduct quarterly meetings with our Kentucky providers to review data specific to their group, including:

- ED utilization based on the day of the week and time of day
- Facilities with the highest ED visit rate
- ED visits by diagnosis

At the population level, when we see trends of increased ED utilization, we engage our **Medicaid Provider Network** team, led locally by Majid Ghavami, to assist in examining network adequacy in areas with high ED usage. We review access to primary care and urgent care centers, as well as opportunities to promote and incentivize after-hours and weekend hours with our PCPs.

Through the real time ED reports we send to our network PCPs, we have seen a statistically significant increase of 21.2% in provider visits following an ED visit, indicating providers are engaging their Enrollees in primary care.

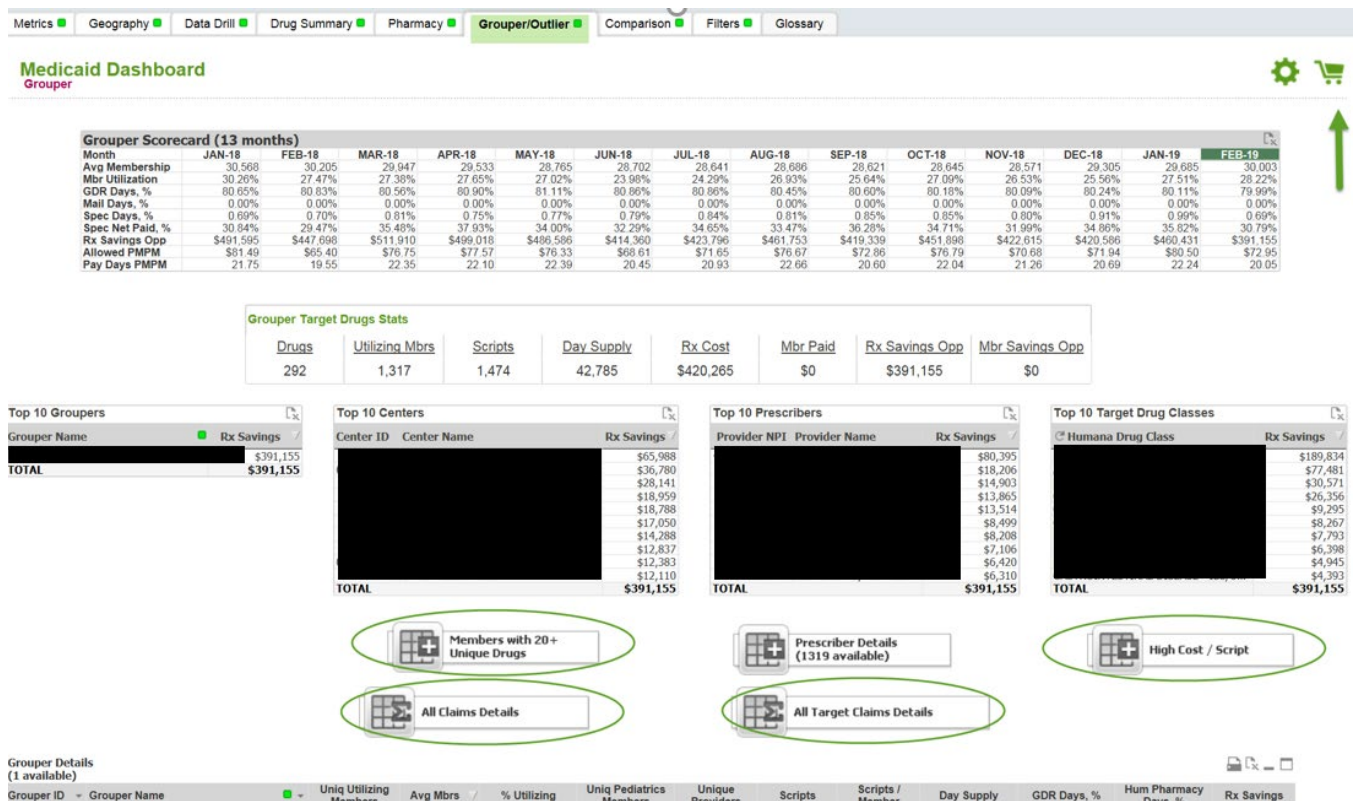
### Pharmacy Utilization

We actively monitor, track, and report on pharmacy utilization and indicators to identify potential areas of overutilization. We monitor and deliver reports to our network providers indicating potential areas of concern, including:

- Enrollees with 15 or more unique drugs: Report identifies Enrollees with 15 or more unique drugs and details the number of prescribers, total prescriptions, and total prescription cost
- High-cost script: Report identifies Enrollees who have 10 or more unique drugs that average more than \$250 per prescription
- All target claims detail: Humana has identified lower cost formulary alternatives for a select number of medications. The report identifies Enrollees who have been prescribed one of the selected medications and provides one to two lower-cost alternatives with associated savings if the prescriber changes the therapy
- All claims detail: Report provides Enrollee, prescriber, and pharmacy claims detail for all pharmacy claims processed within the selected time period
- Pharmacy lock-in program: Humana’s pharmacy lock-in program uses claims activity to identify overuse of benefits and unnecessary costs associated with inappropriate prescription drug use and ED overutilization.

Figure I.C.10-4 below includes a screenshot of our pharmacy analytic systems where we monitor and report on pharmacy utilization.

Figure I.C.10-4: Pharmacy Utilization Dashboard



### Monitoring Opioid Utilization

Drug utilization review (DUR): Through our retrospective DUR we search historic claims to identify Enrollees with potential opioid misuse, including pharmacy claims for opioids originating from more than three providers or three pharmacies. Humana has a **proprietary Opioid Predictive Model to enhance efforts to identify high-risk Enrollees**. We also employ DUR to identify providers with inappropriate prescribing practices.

Point of sale interventions: At the point of sale, we implement utilization management edits using cumulative lookback logic to identify potential opioid misuse, including prescriptions that exceed a set point for daily morphine milligram equivalents (MME), number of days for which initial opioid prescriptions are dispensed, and opioid prescriptions written with more than three months of refills.

From 2016-2018, the number of opioid prescriptions prescribed to Humana-CareSource Kentucky Medicaid Enrollees decreased by 19%.

Targeted provider outreach: When we identify a prescriber with inappropriate opioid prescribing patterns using the methods described below, representatives of Humana Pharmacy and our QIAs will contact that provider to inform them of the dangers inherent in these practices and to encourage a change in their practices. We will also conduct campaigns to educate high-prescribing providers about appropriate prescribing practices. These campaigns have demonstrated positive results: The preliminary results of one campaign, reaching more than 5,000 providers, demonstrated that **26% of providers committed to reducing opioid prescriptions and 22% committed to counseling their patients on substance abuse.**

#### **EXAMPLE #1 – REDUCING INPATIENT ADMISSIONS**

In 2018 we identified an increase in readmissions statewide in our Kentucky MMC program, with all Service Regions exhibiting some increase in readmissions. To address the increase, we identified Enrollees who were inpatient, required transition of care assistance, and had follow-up care needs. We implemented the following initiatives:

- Outreached to identified Enrollees to ensure they had scheduled follow-up care with their PCP and help them schedule a visit if necessary
- Assist those Enrollees with other uncoordinated or fragmented care needs, including SDOH needs, in an effort to close the gaps or barriers

The goals of these interventions included:

- Educate Enrollees on the importance of follow-up care
- Educate providers on the increased need for proper discharge planning
- Design more robust transitional care process within the health plan

Following our interventions, nearly all Kentucky Service Regions showed a year-over-year decrease in 2019. Specifically, the **readmission rate decreased 13% statewide (20% to 7%) from the third quarter of 2018 to the third quarter of 2019. During this time period, Service Region 7 readmissions decreased 62% and Region 6 decreased 24%.**

#### **EXAMPLE #2 – INCREASING ENGAGEMENT IN PRENATAL CARE MANAGEMENT**

From 2017 to 2018, we saw an increase in the percentage of non-birth maternity admissions in our Kentucky MMC program in Service Regions 2 and 4. We developed an initiative to identify pregnant Enrollees as early as possible, and created an associated rewards program. Through claims, pharmacy, and encounter data, we were able to identify in which term the mother was, and care managers targeted those mothers with outreach calls and information on our pregnancy care management. We also utilized our Kentucky Babies First incentive program where Enrollees earn rewards by going to routine doctor visits while they are pregnant and after their baby is born to encourage mothers to receive timely prenatal care.

As a result, the percentage of **maternity admissions that were non-birth related decreased from 31% to 21% statewide from 2018 to 2019** (Year to Date September). Non-birth maternity admissions per thousand **decreased 20% statewide (15.1 to 12.1)** from the third quarter of 2018 to the third quarter of 2019. **During this time period, Region 2 decreased 56%, and Regions 7 and 8 both decreased 50%.**

### **EXAMPLE #3 – URGENT CARE EXPANSION TO COMBAT ED UTILIZATION**

In our Florida Medicaid program, we are actively trying to reduce avoidable ED visits. We saw a 6.3% increase in potentially preventable ED visits from 2016 to 2017. Every month, Humana’s Florida Medicaid Health Services teams meet to review the EIR and discuss emerging trends, year-over-year metric comparisons, additional reporting needs, and initiatives/pilots designed to improve metrics. The metrics and discussions help focus our efforts on areas of opportunity, such as evaluating network adequacy of our urgent care centers (UCC) as a method to decrease avoidable ED visits. Through our multidisciplinary approach in the Medicaid Trend meetings, our clinical and network teams noticed areas of our network that had limited urgent care access, which was driving up ED utilization. In October 2017, Humana launched an urgent care strategy that included contracting with additional UCCs to expand access in Florida. We **saw an immediate 2.6% shift from the ED to urgent care** from 2017 to 2018. Humana is continuing this strategy by launching campaigns to communicate this to both PCPs and Enrollees.

a.iii.

Frequency in which the Vendor proposes to re-evaluate its approaches to identify need for adjustments (e.g., re-evaluation of existing prior authorization requirement for appropriateness)?

We incorporate numerous processes and measures in order to monitor and evaluate progress toward meeting goals and targets. We collect, analyze, trend, and monitor data on a systematic basis to facilitate quality improvement and to address any barriers that we identify. At a minimum, we assess and evaluate our UM program annually through our formal UM program evaluation; however, we continuously monitor, track, and evaluate our approach to UM to identify areas of success and those areas which present opportunities for improvement. We detail these varied approaches below.

### **UTILIZATION MANAGEMENT PROGRAM EVALUATION**

Annually, a multi-departmental Humana team, including representatives from UM, quality, clinical analytics, and provider services, participates in the annual UM evaluation process. The scope of the evaluation is comprehensive. It monitors and evaluates inpatient and outpatient medical care, including BH, delivered by network and non-participating practitioners and health partners. Also monitored are services provided to our Enrollees through physician, hospital, and ancillary quality programs. The evaluation encompasses activities associated with review and authorization of medical and mental health/substance abuse healthcare services, appropriate resource utilization, and oversight of delegated activities. We evaluate the UM program to determine the effectiveness of activities, identification of improvement opportunities, as well as to ensure consistent compliance with regulatory and accreditation requirements using the following core performance indicators:

- Timeliness of UM decisions
- Inter-rater reliability (IRR) for UM decision makers to measure the consistency in which clinical criteria are applied when making UM determinations
- Enrollee and provider satisfaction with the UM process, including:
  - Identification of quality of care issues
  - Aftercare follow up
  - Over and underutilization patterns

Humana continuously monitors and re-evaluates our UM processes. In Q1 of 2020, we examined the prior authorization requirements for occupational therapy, physical therapy and speech therapy. Based on provider feedback and industry standards, we were able to quickly evaluate and adjust the prior authorization requirement.

The evaluation is incorporated into the annual Quality Improvement Evaluation. The ongoing collaboration between our UM associates and the QI program helps us identify opportunities for improvement, intervene with strategies to improve care and services, and drive the ongoing development of clinical programs to meet the needs of the Enrollees and evaluate efficacy of activities. Where analyses indicate unmet goals, we re-evaluate initiatives and goals for potential inclusion in the subsequent calendar year program.

#### **PRIOR AUTHORIZATION LIST REVIEW PROCESS**

Humana's prior authorization program promotes quality of care and optimal treatment options for our Enrollees while controlling costs to the healthcare delivery system. Bi-annually, our cross-departmental team reviews our state-specific Prior Authorization List (PAL) to determine the ongoing appropriateness of services requiring PA. We use specific metrics to determine whether to include a service in the PAL. These metrics include:

- Current claims volume for the service
- Projected Enrollee impact
- Projected provider impact
- Projected Full-Time Equivalent (FTE) impact
- Projected savings
- Estimated approval rate

In addition to the bi-annual formal review, we conduct ongoing reviews of utilization, financial, and quality data, which determine the services that require PA for payment. Services identified with potential quality concerns, including over- or underutilization, may be added to the PAL. This allows Humana to focus on improving quality of care provided to our Enrollees, facilitate the receipt of appropriate services, and improve treatment decisions and health outcomes.

#### **MONTHLY UTILIZATION MANAGEMENT COMMITTEE MEETINGS**

Our Kentucky UM committee provides a venue through which we conduct ongoing evaluations of our UM program. Reporting into our Quality Improvement Committee (QIC), the UM committee is responsible for reviewing medical, BH, and pharmacy utilization data and related statistics, analyzing trends, and recommending improvement strategies. The committee meets at least quarterly and is co-chaired by our Medical Director, Dr. Lisa Galloway, MD, and our BH Director, Ms. Liz Stearman, CSW, MSSW, to promote integration of physical health and BH. When we identify opportunities for improvement, we employ a **rapid cycle improvement process** through which we identify, develop, and implement solutions on an ongoing basis rather than waiting until the annual evaluation. Additionally, we will **implement a subcommittee of the UM committee devoted to reviewing and evaluating our UM operations and processes**, identifying opportunities to make our process more efficient, and continuing to reduce burdens on providers wherever possible.

#### **QUALITY IMPROVEMENT COMMITTEE**

Humana's Kentucky QIC, also led and chaired by our Medicaid Medical Director Dr. Lisa Galloway, MD, is our state-based quality committee dedicated to overseeing the overall quality program and ensuring quality improvement activities take place throughout our organization. Our Kentucky QIC **meets monthly** and will direct and review all Quality Management (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 Humana Kentucky QIC participants include network practicing physicians, advanced practice nurses (APN), and Humana clinical associates with the QIC fostering discussions regarding policy, programs, and quality initiatives.

#### **SATISFACTION WITH THE UM PROCESS**

Humana monitors both Enrollee and provider satisfaction with the UM process at least annually. Mechanisms for evaluating Enrollee satisfaction include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 4.0H Survey (questions 22 and 26 of the Medicaid insured version) and tracking Enrollee complaints and compliments that relate specifically to UM. We collect provider satisfaction with UM at least annually by way of



a provider satisfaction survey. We also track provider complaints that relate specifically to UM and solicit feedback from network providers serving on health plan committees, particularly the QIC. We evaluate and use this information to improve satisfaction with the process. We solicit Enrollee feedback regarding their experience with Humana via our CAHPS surveys as well as through our Quality and Member Access Committee (QMAC) comprised of community stakeholders and Humana Enrollees.

Internally, we use our Enrollee 360 and Provider 360 committees as our multidisciplinary approach to addressing Enrollee and provider concerns. These cross-functional meetings bring together internal business units to review data and develop strategies to improve the Enrollee and provider experiences.

#### Humana’s Enrollee 360 Committee

The Kentucky Medicaid Enrollee 360 Committee’s goal is to systematically identify ways to improve the Enrollee experience. The Committee meets monthly to review all metrics applicable to Enrollees, including grievance and appeals data, and provides a forum for reviewing Enrollee-related metrics, root cause analysis, process improvement opportunities, and escalation of Enrollee concerns.

At each meeting, the committee reviews total receipts, number overturned, number upheld, and the top overturn reason. The Committee provides the opportunity to ask questions about the denials we reviewed to see if their areas have any impact on educating Enrollees or providers regarding specific service types.

#### Humana’s Provider 360 Committee

The Kentucky Provider 360 Committee is a Medicaid-focused committee that **meets once a month** in an effort to advance our provider support and improve provider engagement and satisfaction in all markets. During these meetings, committee members review administrative improvement opportunities and functional areas to improve provider experience through review of provider utilization metrics, identification of process improvement and provider performance opportunities, and development of provider education initiatives and materials.

b.

Describe the Vendor’s proposed Utilization Management (UM) Program, assuring that it addresses requirements of RFP Attachment C **“Draft Medicaid Managed Care Contract and Appendices.”** In the description, include information about the following, at a minimum:

#### **OVERVIEW OF HUMANA’S UM APPROACH**

Humana employs a dynamic, person-centered UM program, led by our UM Director Kathy Kauffmann, to provide comprehensive delivery of healthcare services and to ensure our Enrollees receive the appropriate level of care based on medical necessity. Our UM program is evidence-based and guided by nationally recognized clinical guidelines. We have built our UM program upon decades of lessons learned serving high-need populations on a large scale, and we continually enhance the program based on our experience. We integrate physical health, BH, and pharmaceutical management in all phases of the program while also recognizing the critical impact of social factors. The program includes evaluation of clinical utilization guidelines and criteria; patterns of utilization; analysis of Enrollee-based, population-level and Enrollee-level data; and the development of interventions to positively affect health outcomes. Our processes encompass activities associated with review and authorization of medical services, mental health and substance abuse services, appropriate resource utilization, and discharge planning. We strive to coordinate and cooperate with providers in the Humana

Humana has established policies and procedures in place to meet the requirements set forth in Section 20.0 of the Draft Medicaid Contract.

delivery system to reduce administrative burden and provide a comprehensive approach that meets the medical needs of our Enrollees, ranging from episodic management to the routine coordination of care, acute and post-acute care and preventive care and care management.

The program is integrated into the PHM Model, which includes UM, quality improvement, care management, and population health management. In addition, the UM program collaborates with the Pharmacy department and considers the integration of physical health, BH, and pharmaceutical management in all phases of our activities.

### Delegation of UM Functions

In our Kentucky Medicaid Program, Humana delegates UM functions for dental services to our strategic dental and vision partner, Avësis, as well as to New Century Health, which reviews part B injectable or infusible medication requests. As part of our enterprise-wide delegation policy, we conduct delegate oversight activities consisting of onsite visits, audits, and review of required reports and all relevant documentation related to specific delegation functions for compliance to Humana, regulatory, and accreditation standards. Delegated entities' performance is monitored by the **Subcontractor Oversight Committee**. Summaries of Subcontractors' performance are forwarded to the Kentucky QIC on a monthly basis. We require implementation of corrective action or quality improvement plans if our delegates only partially meet these standards, with re-review and ongoing oversight conducted to ensure they correct the identified deficiencies. Oversight of delegation activities is an ongoing process and may include the following:

- Reporting requirements
- Site visits and audits
- Annual evaluation
- Corrective action or improvement plans
- Reporting to corporate or market committees accountable for ongoing oversight
- Attendance and participation in Joint Operating Committee (JOC) meetings and other meetings as necessary

#### **b.i.** Approach to align the UM Program with the Department's required clinical coverage policies.

Humana's experience operating multiple lines of business across all 50 states and Puerto Rico has allowed us to develop best practices in aligning our internal UM policies and procedures with State and federal regulations, National Committee for Quality Assurance (NCQA) standards, and Commonwealth of Kentucky benefits coverage. Our UM Committee reviews internal coverage policies to ensure we are in alignment with our State partners; these policies are updated at least annually and as we identify changes.

To ensure we align with the Department's clinical coverage policies, we use established clinical practice guidelines (CPG) as the foundation of our written policies and procedures on medical decision-making. As such, we adopt CPGs from clinically sound and reputable organizations, ensuring they reflect current standards of medical practice and are based on community-based practice guidelines and literature established by national organizations, including but not limited to:

- Agency for Healthcare Research and Quality (AHRQ)
- American Diabetes Association (ADA)
- Centers for Disease Control and Prevention (CDC)
- National Committee for Quality Assurance (NCQA)
- American Psychiatric Association (APA)
- American Academy of Child and Adolescent Psychiatry (AACAP)
- American Society of Addiction Medicine (ASAM)

We develop CPGs in consultation with network providers as well as out-of-network (OON) experts who participate on the Clinical Practice Guideline Committee. **Providers can provide input and advice on clinical policy development and provider operations through our QIC.**

**b.ii.** Proposed evidence-based decision support tool(s).

**UM CLINICAL CRITERIA AND REVIEW PROCESSES**

Under appropriate supervision by a registered nurse (RN) or licensed mental health professional (LMHP), experienced medical professionals with an active and valid Kentucky license (e.g., licensed practical nurses) use approved clinical decision support tools to review requests against plan benefits and established criteria. When reviewing requests, we apply all contractual, State, and federal guidelines, including Centers for Medicare and Medicaid Services (CMS) transmittals and Medicaid Contractor Bulletins. We maintain a corporate license to use **MCG Care Guidelines**, which are externally developed, peer-reviewed, evidence-based, standardized criteria created to support effective UM. Managed Care Organizations (MCO) and hospitals across the industry use MCG Care Guidelines to drive evidence-based care. We selected these nationally recognized, industry-leading criteria because they are based on clinically validated best practices that support optimal clinical decision-making. We use MCG Care Guidelines for the following areas: inpatient and surgical care, ambulatory care, BH, general recovery care, recovery facility care, and chronic care. MCG Care Guidelines are reviewed and updated at least annually, and more frequently as needed, to reflect updates and changes in practice standards. We also use **ASAM criteria** when reviewing cases involving substance use disorder (SUD).

While clinical associates and Medical Directors use these criteria (which apply for all care acuity levels), they do not replace clinical judgment. UM review nurses approve services if they meet clinical criteria. We review UM decisions based on the hierarchy included below:

1. State-specific Medicaid coverage manuals
2. Enrollees' Medicaid Enrollee Handbook and Benefit Grid
3. Humana Medical Coverage Policies
4. MCG/ASAM
5. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines (as applicable)

When necessary, we supplement MCG with evidence-based tools and guidelines from nationally recognized organizations such as:

- American Academy of Child and Adolescent Psychiatry (AACAP)
- American Diabetes Association (ADA)
- American Heart Association (AHA)
- American College of Chest Physicians (ACCP)
- Centers for Disease Control and Prevention (CDC)
- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- National Center for Trauma-Informed Care (NCTIC)
- American College of Obstetricians and Gynecologists (ACOG)
- Agency for Healthcare Research and Quality (AHRQ)
- American Psychiatric Association (APA)
- American Society of Addiction Medicine (ASAM)
- National Quality Forum (NQF)

We ensure our reviews are flexible enough to allow deviations from the norm, when justified, and consider special circumstances on a case-by-case basis. We consider at least the following when applying criteria to an individual:

- Age
- EPSDT
- Co-morbidity
- Progress of treatment
- Complications
- Psychosocial situations

- Home environment
- Cultural needs
- Safe Discharge Plan

We also consider the characteristics of the local delivery system available to specific enrollees, including:

- Availability of post-acute service
- Coverage of post-acute services, as medically appropriate
- Local hospitals' ability to provide all recommended services within the estimated length of stay
- Availability of inpatient, outpatient, and transitional facilities
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of outpatient services in lieu of inpatient services

**UM training:** To ensure we consistently apply review criteria for authorization decisions, Humana provides initial and ongoing education for our UM associates and network providers on our UM program, including clinical guidelines, PALs, and determination of medical necessity. Upon hire, UM associates receive four weeks of robust training, followed by four to six weeks of preceptor training where an experienced UM associate mentors the new associate. We also conduct 30 and 90-day post-training surveys. We notify associates when we revise policies and procedures, and review them individually, as teams, and/or through special in-service updates.

b.iii.

Innovations and automation the Vendor will implement, for example, to reduce provider administrative burden under the UM Program.

Humana values our provider partnerships, and we work collaboratively to develop strategies to deliver effective and efficient care. We have implemented multiple initiatives to help reduce provider administrative burden.

#### **AUTOMATED PROVIDER AUTHORIZATION SUBMISSION PROCESS**

Humana's **service authorization processes are fully automated** through our online provider portal, Availity. Network providers may submit service authorization requests and upload supporting clinical documentation on Availity's authorization platform. Once submitted through Availity, the authorization request is routed through our logic-driven processes within our clinical workflow system, CGX. Our processes automatically notify requesting providers through Availity upon authorization determination.

#### **GOLD CARD PILOT PROGRAM FOR HIGH-PERFORMING PROVIDERS**

Humana's Gold Card program is aimed at increasing provider simplification and reducing providers' administrative obligations. Our Gold Card Program uses a blend of quality and performance measures to identify the highest-performing providers. Through reviewing provider's quality (using Humana's Care Highlights program) and utilization (percent of authorizations approved), we can identify those providers who deliver high-value care, close care gaps, and refer Enrollees for appropriate services and follows ups. When high-performing providers meet specific targets for certain measures, they will have the ability to bypass the standard outpatient PA process for the following services: referrals for specialty care, in-office or ambulatory surgery procedures prevalent with specialty providers, small molecule prescription (Rx) products, high-cost biologics, and high-tech imaging (CT/MRI). This program helps us achieve mutual quality and access goals while reducing the administrative burden on providers. We are implementing this pilot in our Florida Medicaid program in 2020, and we will implement a similar pilot in our Kentucky Medicaid program in early 2021.



## CARE DECISIONS INSIGHTS

Care Decisions Insights (CDI) is a tool that identifies specialists who demonstrate high efficiencies and effectiveness in their care delivery. We share this information with providers, which allows them to improve their patients' care by referring them to these specialists delivering high value care. CDI encourages provider groups to consider and incorporate cost and quality insights into their referral decisions. For PCP groups, CDI data may provide reassurance that specialists are recognized for delivering quality, high-value care and improved patient outcomes. **Through our innovative CDI platform, we give PCPs information about the most efficient and effective specialists in Humana's network.** For specialists, the CDI program gives details regarding how their performance compares to that of their peers. We include results of CDI in the public Provider Directory, allowing PCPs and Enrollees to choose their preferred providers based on their quality score. Our goal is to use CDI to direct care to providers who have a proven track record of delivering high-value care.

## ELECTRONIC HEALTH RECORD ACCESS

Humana **has built direct connections with eight of the top electronic health record (EHR) software** vendors providing near real-time clinical data via continuity of care documents (CCD) from our network providers, as well as Admission, Discharge, and Transfer notifications, if the vendor is capable. This allows us to access the required clinical documentation for authorization requests. Once the authorization is placed, our systems pull necessary information from the CCDs to complete authorizations.



The EHRs we work with are in varying stages of providing the following capabilities to reduce provider administrative burden. Humana works in partnership with EHRs and has made significant investments to enhance capabilities for data sharing between provider and payer.

- **Chart Retrieval:** Humana receives encounter records for the purpose of health plan operations, either via a request/response process, or automatic feed based on payer identifier in the EHR.
- **Hospital Notifications:** Humana receives ADT notifications that allow Humana to know, in near real time, about the activity of Humana Enrollees in participating facilities. These notifications support care management processes as well as authorization management.
- **Pharmacy Integration:** Humana can deliver real-time prescription coverage and patient cost information with lower-cost alternatives and mail benefit information, as well as real-time care alert integration. Humana also allows for electronic pharmacy PA submission within an EHR order entry.
- **Practitioner Assessment Forms (PAF):** Humana is working with EHRs to develop PAF templates and connections to allow for the CMS annual form to be completed by the provider and delivered to Humana in a more effective fashion by transitioning from a paper/fax model.

## INTERNAL AUTOMATED AUTHORIZATION SYSTEM CAPABILITIES

We have optimized our internal authorization system capabilities to decrease authorization turnaround times thus decreasing the amount of time our providers must wait for a service determination. At the center of Humana's UM system capacity is CareHub, Humana's enterprise solution for complete program integration for Humana providers and Enrollees. We have configured CareHub to support authorization determination efficiency, promote accuracy in service determination decisions, and reduce the administrative burden on our providers by automating internal UM processes using logic-driven programming. Our clinical workflow system, CGX, supports an integrated approach to UM, processing both physical and BH service authorization requests. Authorization requests for inpatient and outpatient services to CareHub are processed and automatically fed to CareHub's clinical rules engine, Anvita. Automated features supporting UM activities include:



- Automated routing of new authorization requests to the appropriate internal team
- Routing of authorizations with date and time stamps within system
- Electronic capture of provider clinical information to support UM decisions

- Links to useful tools, such as MCG guidelines and our Customer Care system, to enhance user efficiency
- UM letters, such as “Notice of Action,” integrated within system
- Automated business rules integrate with PAL to automatically approve, as appropriate, or send in “real time” to appropriate clinical team for review
- Integration of our clinical platform for UM and care management, including physical health, BH, and SDOH

**b.iv.**

Methods and approach to balance timely access to care for Enrollees with the administration of the UM Program.

Appropriate care and efficient delivery of services are the cornerstones of Humana’s UM processes, ensuring our Enrollees receive the right care, at the right place, at the right time. We use the following methods to balance timely access to care for our Enrollees with the efficient administration of our UM program.



**PRIOR AUTHORIZATION LIST (PAL)**

Our prior authorization program promotes the efficient delivery of quality, optimal, and appropriate treatment options for our Enrollees. Ongoing review of utilization, financial and quality data, and the State agency fee schedule determines services that require PA for payment. Humana uses specific metrics to determine whether to include a requested service in the PAL, including:

- Overutilization, underutilization, and inappropriate utilization
- Potential quality of care issues
- Trends of services not meeting nationally recognized, evidence-based criteria for medical necessity
- Current claims volume for the service
- Projected Enrollee impact
- Potential provider impact

Our PAL considers the benefit coverage and relevant regulations of the State’s Medicaid program. The PAL team includes representatives from the following departments and functions:

- Clinical and Quality Leadership teams
- Medical Director, Dr. Lisa Galloway, MD
- Behavioral Health Director, Liz Stearman, CSW, MSSW
- Provider Network
- Clinical Strategies
- Clinical Intake Team (CIT)
- Complaints and Appeals
- Provider Communications (including feedback from our Kentucky Provider Advisory Committee)
- Claims

Avēsis reviews PA data for dental services annually to determine the need for continued monitoring. If 90% or more of requests were approved for a specific service during the year, senior members of the Avēsis Clinical Management team remove the service from the PAL to minimize provider burden.

**SERVICE AUTHORIZATION PROCESS**

As mentioned earlier, our service authorization processes are rooted in the goal of ensuring our Enrollees receive efficient and effective care. To balance the need for service authorizations for certain services with our Enrollees’ need for timely access to care, we strive to conduct and complete authorization reviews as quickly as possible. We believe that UM processes and determinations should take place in a timely, efficient manner and should have minimal impact on network providers and Enrollees. Our automated processes reduce provider burden and ensure our providers can deliver the appropriate care to our Enrollees when they need it.

**We processed 37,048 authorizations in 2018** for our Kentucky Medicaid Enrollees and were successful in meeting contractually required timeframes associated with standard, expedited, concurrent/urgent, and

retrospective reviews. **Table I.C.10-2** includes our compliance with service authorization timeframes in our Kentucky Medicaid Program.

**Table I.C.10-2: Humana Kentucky and Florida Medical Authorization Timeline Compliance - 2018**

Authorization Type	Kentucky Compliance Rate
Standard	97%
Expedited	98%
Concurrent/Urgent	97%
Retrospective	99%

**UTILIZATION CRITERIA REVIEWS**

We understand there cannot be a one-size-fits-all approach to determining the appropriate services for all of our Enrollees. Humana provides guidance to Enrollees and facilitates coordination of care as Enrollees navigate the healthcare delivery system.

We ensure our clinical reviews are flexible enough to allow deviations from the norm, when justified, and consider special circumstances on a case-by-case basis. We empower our UM clinicians to consider at least the following when applying decision criteria to a service request:

- Age
- EPSDT
- Co-morbidity
- Progress of treatment
- Complications
- Psychosocial situations
- Home environment
- Cultural needs
- Safe discharge plan

We also consider the characteristics of the local delivery system available to specific Enrollees, including:

- Availability of post-acute services
- Coverage of post-acute services, as medically appropriate
- Local hospitals' ability to provide all recommended services within the estimated length of stay
- Availability of inpatient, outpatient, and transitional facilities
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of outpatient services in lieu of inpatient services

**MEDICAL NECESSITY DETERMINATIONS**

Our UM program ensures that Enrollees receive safe, medically appropriate services. Experienced nurses and licensed mental health professionals (LMHP) with an active and valid license and the qualifications to perform UM in Kentucky will use approved clinical criteria to perform medical necessity reviews. Appropriately licensed professionals will actively supervise these nurses. When conducting reviews, our Utilization Review (UR) associates accept information from various sources, including all submitted clinical information, to assist in the authorization process. Clinical associates review whether requests meet plan benefits and established criteria and may either approve services meeting criteria or refer the review to a physician when the request has not met criteria. Medical Directors and other licensed physician reviewers will use available criteria and clinical judgment to render a decision based on medical necessity. We offer a peer-to-peer review process for our network providers through which they can consult with an experienced Medical Director with the requisite background and specialization based upon individual cases to discuss the details of a case prior to rendering a determination. Medical Directors are the only clinical associates that can render adverse coverage determinations based on unmet criteria for establishing medical necessity.

## **TIMELY ACCESS TO SERVICES**

Humana uses additional innovative approaches to ensure we balance our UM program with timely access to care. We use our **Enrollee Services team**, led by Sarah Porter, as an extension of our UM and care management teams to help our Enrollees identify providers who meet their needs and can see them as soon as possible. We also use our **Care Management team** as a resource for our Enrollees to guide them through appointment scheduling and finding providers with availability.

To increase timely access to necessary services for our Enrollees in more rural areas where there may be more limited access to providers, such as Eastern Kentucky, we **offer telemedicine and telepsychiatry services through MDLIVE**. Enrollees can access preventive services, consult a physician for urgent care needs, and receive prescriptions based on their needs. Humana has partnered with **Arcadian Telepsychiatry** to provide Humana Enrollees with access to a broad network of licensed and credentialed psychiatrists, psychologists, and other BH therapists. These providers collectively offer a full suite of BH and wellness services. The technology for scheduling and videoconferencing is set up inside a PCP's office and is accessible through a secure portal, creating a seamless experience for the patient, referring physician, and Arcadian provider. We will also provide a telepsychiatry solution for providers in EDs who need a **psychiatry consult**, but do not have an available psychiatrist on staff.

Finally, we look for **opportunities to enhance our provider network** when we notice longer than average wait times to see a provider or our internal **EIR** shows overutilization of ED services due to a lack of primary care.

### **EIR in Action: South Florida ED Utilization**

When Monroe County's ED visits per thousand radically increased, Humana's Health Services department requested a PCP and urgent care geomap to ensure our Enrollees had access to care in more appropriate settings. The resulting map and feedback from Humana's Provider Network team showed a lack of UCC options for our Monroe County Enrollees. The Health Services team then worked with Provider Network to identify UCC contracting opportunities in order to expand access to care and

**b.v.** Approach to integrate medical and behavioral health services in the UM program.

Humana operates an integrated clinical model through which our Enrollees receive all medically necessary covered services. Our UM program integrates medical and BH services through the following mechanisms.

### **FULLY INTEGRATED CLINICAL PLATFORM**

Over the last several years, we have made significant investments in our integrated clinical platform, CGX, to support the efficient delivery and coordination of Covered Services. CGX's functionality enables direct management of medical, BH, and social services, enhancing our ability to automate service authorizations, document gaps in care, automate care planning, monitor plan compliance, and proactively address co-occurring needs and changes in condition.



We automatically route and process medical and BH service authorizations through CGX, allowing Humana clinical associates to have a complete, integrated view of our Enrollees' clinical information and authorized services.

### **MULTIDISCIPLINARY TEAM MEETINGS**

MDT meetings serve an important care management function, particularly for Enrollees with complex and/or co-occurring BH and medical needs. MDT meetings are opportunities for our integrated CCS team to come together to review current authorized services and care plans for specific. The Enrollee's CM, who may have both a BH



and medical background based on the Enrollee's needs and leads the MDT meetings, gathers feedback on the Enrollee's care plan from their support system, providers, and other individuals identified by the Enrollee. This feedback is incorporated into the Enrollee's care plan. This cross-functional discussion forum of our Enrollee's needs fosters a holistic approach to UM and facilitates coordination of care and discharge planning.

### **UM ROUNDS**

We conduct UM rounds to provide a forum for regular case discussions and create an opportunity for group learning. We hold these meetings monthly with a team of medical and BH professionals and physicians responsible for UM determinations and discharge planning. The discussions foster clinical learning and development, consistent decision-making, trend identification, and sharing of QI ideas.

### **FULLY INTEGRATED STAFFING MODEL**

Humana brings a fully integrated staffing model to Kentucky. Our operational model is designed to address our Enrollees' physical health and BH, incorporating both our **Kentucky-based physical and BH UM associates in a co-location model**. Our CCS team also supports our medical and BH integration, providing a forum for our associates with expertise in physical health, BH, and the SDOH needs of the Medicaid population to exchange information and ideas and support Humana Enrollees with co-occurring, complex needs. This team structure allows our Enrollees to access a single point of contact for their care needs, even if they have co-occurring physical health or BH needs. During our UM rounds, BH associates, physical health associates, as well as network providers and CMs, discuss how best to integrate physical health and BH to produce the best health outcomes for the Enrollee. Our **Kentucky Medical Director, Dr. Lisa Galloway, MD, and BH Director, Ms. Liz Stearman, CSW, MSSW, will co-chair our Kentucky UM Committee** to promote integration in clinical decision-making.

#### **b.vi.** Approach to ensure UM Program is compliant with mental health parity.

Humana is committed to ensuring the Final Medicaid/Children's Health Insurance Program (CHIP) Parity Rule ("Final Rule") requirements are embedded throughout all Humana Medicaid operations. Humana understands that the Final Rule requires that the states, or the MCO if the MCO is conducting the parity analysis, must perform an analysis of limits on mental health and substance use disorder ("MH/SUD") benefits that involve financial requirements, quantitative treatment limitations (QTL), and aggregate lifetime or annual dollar limits. Humana is prepared to perform such analysis, if necessary, in collaboration with the Commonwealth and follow the required two-step parity analysis testing to determine the predominant financial requirement by type applied to substantially all medical/surgical benefits in the defined classifications prescribed by the Commonwealth.

Under the Final Rule, a non-quantitative treatment limitation (NQTL) is a limit on the scope or duration of benefits. Humana's processes, strategies, evidentiary standards, or other factors used in applying NQTLs to MH/SUD in a classification are designed to be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in such classification in accordance with Final Rule. Humana has instituted processes, controls, and governance to set and monitor compliance with NQTLs. Below is a summary of Humana's NQTLs, including, but not limited to:

- **Medical necessity standards:** Humana applies nationally recognized clinical criteria standards to both BH and physical health determinations. Humana makes the criteria for medical necessity determinations with respect to MH/SUD benefits available to any current or potential participant, Enrollee, or contracting provider upon request
- **Prior or ongoing authorization requirements:** Humana's prior authorization program promotes the efficient delivery of quality, optimal, and appropriate treatment options for our Enrollees across both

medical/surgical and MH/SUD services. Humana uses specific metrics to determine whether to include a requested medical/surgical or MH/SUD service in the PAL, including, but not limited to:

- Overutilization, underutilization, and inappropriate utilization
- Potential quality of care issues
- Trends of services not meeting nationally recognized, evidence-based criteria for medical necessity
- Current claims volume for the service
- Projected Enrollee impact
- Potential provider impact
- Cost per episode
- New/emerging technology
- Utilization review requirements: Humana utilizes MCG guidelines for both physical health and BH determinations, providing a basis for consistent decision-making. In compliance with Draft Medicaid Contract requirements, we will apply ASAM guidelines for SUD services. Clinical reviews are managed within the parameters established by published NCQA guidance, as well as applicable State and federal regulatory requirements. To ensure we consistently apply review criteria for authorization decisions, Humana provides initial and ongoing education for our UM associates and network providers, including clinical practice guidelines, PALs, and determination of medical necessity. We perform inter-rater reliability studies of physician and non-physician reviewers at least annually, as well as monthly audits on UM associates, to ensure that criteria are applied consistently and are not more stringently applied to BH as compared to medical/surgical benefits.
- Experimental and investigational definitions: Humana utilizes consistent definitions for experimental and investigation for both MH/SUD and medical/surgical benefits.
- Pharmacy formulary design: Humana's Pharmacy and Therapeutics (P&T) Committee applies an evidence-based review process in developing the formulary and PA criteria, in compliance with the following guidelines:
  - The pharmaceutical must be approved for marketing by the FDA.
  - The pharmaceutical should reasonably improve the net health outcome. The pharmaceutical's known beneficial effects on health outcomes as demonstrated by the evidence review should outweigh any known harmful effects on health outcomes.
  - The improvement must be attainable outside the investigational setting.
- Denial Rationale: Humana informs providers and Enrollees of the clinical rationale used as the basis for a medical necessity determination in individual adverse determination letters.
- Providing out-of-network (OON) coverage for medical/surgical benefits and OON coverage for MH/SUD benefits: As medically necessary, Humana provides OON coverage for M/S and MH/SUD benefits. Enrollees and providers can follow the same process for requesting OON coverage whether the benefit is medical/surgical or related to MH/SUD.

**b.vii.**

Approach to ensuring accountability for developing, implementing, and monitoring compliance with Utilization policies and procedures and consistent application of criteria by individual clinical reviewers.

**MECHANISMS TO ENSURE CONSISTENT APPLICATION OF REVIEW CRITERIA**

Our UM program is based upon the equitable application of review criteria. Our experience has shown that consistency in the UM decision-making process is critical to uniformly apply medical necessity by physician and non-physician reviewers. Since non-physician reviewers cannot deny a request for services, it is essential that these associates understand the criteria that will allow them to approve a request.

Each year, Humana conducts testing of reviewers using methods endorsed by the NCQA. We create hypothetical cases that mimic the types of cases we typically present to our reviewers. Each case (question) has a clinical

stem serving as the basis for a selection of choices by the reviewer (examinee). The hypothetical cases focus on the application of MCG criteria and Humana Medicaid policies, and we review the cases and preferred answers with examinees. UM associates, including physicians, must score at or above 80%. If they score less than the threshold, they must re-take the examination. If they score less than the threshold on their second try, they will undergo additional training. We also ensure consistent application of review criteria using the following methods.

**Inter-rater Reliability (IRR):** Physician and nurse reviewers render decisions to approve or deny based upon medical necessity, clinical judgment, and clinical guidelines knowledge. To identify consistency of physician decisions, we employ IRR using a multiple-choice examination based on de-identified cases or hypothetical questions. We then calculate a kappa statistic to evaluate the level of agreement on each item. We consider a kappa equal to or greater than 0.8 good agreement. For items with a kappa less than 0.8, the group of physician reviewers will review and discuss to improve the quality of our reviews. We perform IRR audits of physician and non-physician reviewers at least annually to measure their consistency in applying criteria in UM decision-making.

Following low IRR results in Q1 and Q2 of 2018 in our Kentucky Medicaid Program, we implemented MCG instructor-led trainings on inpatient and surgical guideline reviews in May and August of 2018. **IRR results improved from 64.6% compliant in Q2 to 95.8% compliant in Q4.**

**Monthly Audits:** We conduct monthly audits on UM associates making medical necessity determinations to ensure consistency in decision-making. We review one percent of each UM professional's determinations each month to ensure criteria application consistency.

**Grand Rounds:** Humana understands the value of creating a forum where clinical associates can come together to discuss consistency in clinical decision-making. We conduct grand rounds to provide a forum for regular case discussions and create an opportunity for group learning. We hold these meetings monthly with a team of medical and BH professionals and physicians responsible for UM determinations and discharge planning. UM nurse leaders or physicians choose the cases. The discussions foster clinical learning and development, consistent decision-making, trend identification, and sharing of QI ideas. The goal is to apply consistent criteria, decision-making, and best practice implementation among the UM clinical teams.

**UM Training:** To ensure we consistently apply review criteria for authorization decisions, Humana provides initial and ongoing education for our UM associates and network providers on our UM program, including clinical practice guidelines, PALs, and determination of medical necessity. Upon hire, UM associates receive four weeks of robust training, followed by four to six weeks of preceptor training where an experienced UM associate mentors the new associate. We also conduct 30- and 90-day post-training surveys. We notify associates when we revise policies and procedures and review them individually, as teams, and/or through special in-service updates.

**b.viii.** Processes and resources used to develop and regularly review Utilization Review (UR) criteria.

Humana's Utilization Review (UR) criteria are developed using all contractual, State, and federal guidelines, including CMS transmittals and Medicaid Contractor Bulletins. We maintain a corporate license to use **MCG Care Guidelines**, which are externally developed, peer-reviewed, evidence-based, standardized criteria created to support effective UM. MCOs and hospitals across the industry use MCG Care Guidelines to drive evidence-based care. We selected these nationally recognized, industry-leading criteria because they are based on clinically validated best practices that support optimal clinical decision-making. We use MCG Care Guidelines for the following areas: inpatient and surgical care, ambulatory care, BH, general recovery care, recovery facility care, and chronic care. MCG Care Guidelines are reviewed and updated at least annually, and more frequently as

needed, to reflect updates and changes in practice standards. We also use **ASAM criteria** when reviewing cases involving SUD.

When necessary, we supplement MCG with evidence-based tools and guidelines from nationally recognized organizations such as:

- American Academy of Child and Adolescent Psychiatry (AACAP)
- American Diabetes Association (ADA)
- American Heart Association (AHA)
- American College of Chest Physicians (ACCP)
- Centers for Disease Control and Prevention (CDC)
- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)
- National Center for Trauma-Informed Care (NCTIC)
- American College of Obstetricians and Gynecologists (ACOG)
- Agency for Healthcare Research and Quality (AHRQ)
- American Psychiatric Association (APA)
- American Society for Addiction Medicine (ASAM)
- National Quality Forum (NQF)

Humana’s UM committee evaluates and approves UR criteria on an annual basis. Chaired by our Kentucky Medicaid Medical Director, Dr. Lisa Galloway, MD, and our BH Director Ms. Liz Stearman, CSW, MSSW, the UM committee reviews relevant literature and best practices and adopts and/or establishes criteria that promote quality, cost-effective care. As mentioned earlier in this response, we adopt best practices and CPGs from various nationally recognized organizations to inform our UR criteria.

Additionally, we perform an internal review of the updated MCG criteria annually, when we review any new or significantly changed guidelines as well as any deleted guidelines, guidelines with name changes, and newly implemented tools.

**b.ix.**

Prior Authorization processes for Members requiring services from non-participating providers or expedited Prior Authorization, including methods for assuring services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope.

Humana’s prior authorization processes operates under a “no wrong door” policy for submitting authorizations; we are available 24 hours a day, 7 days a week to accept and process authorizations, regardless of the source or type. Due to our broad provider network in our Kentucky Medicaid program, requests from non-participating providers are less prevalent. Below we outline our approach to authorizations from non-participating providers when applicable, and expedited service authorizations.

**AUTHORIZATIONS FROM NON-PARTICIPATING PROVIDERS**

**OON Providers:** Humana is committed to providing necessary services for Enrollees even when those services may be OON. In most instances, our Enrollees must obtain authorization from the plan prior to seeking care from an OON provider. **Exceptions include emergency services, post-stabilization services, and urgent care services, which require no PA for OON services.** The Humana Medical Director, Dr. Lisa Galloway, MD, determines when exceptional referrals to OON-specially-qualified providers are needed to address the unique medical needs of an Enrollee (e.g., when an Enrollee’s medical condition requires testing by a geneticist). This determination is based upon medical necessity and provider availability and expertise.

If an Enrollee chooses to seek non-network care when *equivalent care* is available within network, the benefits for those services will be processed according to the provisions in their Enrollee Handbook. *Equivalent care* means there is no perceived difference in quality or potential outcomes. OON authorizations are not appropriate if alternative procedures providing similar outcomes are available in network. In this case, Humana will not approve the OON services unless there is a specific medical necessity for that treatment that cannot be met in network.

If medically necessary covered medical care is not available from providers in our network, Enrollees can seek this care from an OON provider. Under these circumstances, Humana will seek to bring that provider into our network through a single case agreement.

**Continuity of Care:** Humana is committed to continuity of care and Enrollee safety. For coordination and continuity of care, Enrollees new to Humana who are under treatment with a non-participating provider are evaluated and may be able to continue the treatment plan until it is appropriate to complete a transfer. An Enrollee may be referred to an OON provider if the Enrollee needs medical care that can only be received from a physician or other healthcare provider who is not participating in our health plan. We define a consistent process for one-time rate negotiation ensuring quality, cost-effective delivery of medically necessary services to eligible Enrollees. We will also apply continuity of care considerations when providers terminate their contract with Humana.

If an Enrollee is undergoing ongoing medically necessary covered treatment, Humana may create an ongoing authorization for a specified duration of time or number of treatments to complete the expected course of care. Humana also:

- Assists PCPs in managing the total care of our Enrollees by assisting with referrals to OON providers if participating providers are unavailable or inadequate to meet the Enrollee's medical need or if there are continuity of care issues such that transferring care to a participating provider would jeopardize the Enrollee's health
- Ensures that non-participating providers are Medicaid-certified before authorizing services to treat Enrollees
- Ensures that Enrollees have access to all medically necessary services covered by Medicaid
- Educates our Enrollees on the availability of OON providers in certain situations in the Enrollee Handbook. Denial letters are Medicaid approved, in layman's language, and provide Enrollees with their rights regarding grievances and appeals.

### **EXPEDITED SERVICE AUTHORIZATIONS**

For cases in which a provider or Enrollee indicates or Humana determines that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, **Humana makes an expedited authorization decision within 24 hours** and provides notice as expeditiously as the Enrollee's health condition requires and no later than three business days after receipt of the request for service. Requests that are received as STAT, Urgent, Expedited, Fast, and/or immediately are triaged to determine if the request meets the expedited requirement(s). We expedite a request if it meets any one of the following conditions:

- An Enrollee or an Enrollee's appointed or authorized representative requests an expedited decision, and Humana determines that applying the standard timeframe for making a determination could seriously jeopardize the Enrollee's life, health, or the ability to regain maximum function
- An Enrollee or an Enrollee's appointed or authorized representative requests an expedited decision and a physician provides verbal or written support for the Enrollee's expedited request
- A physician requests an expedited decision and indicates (either verbally or in writing) that applying the standard timeframe for making a determination could seriously jeopardize the Enrollee's life, health, or the ability to regain maximum function (the physician does not have to use these exact words). The physician does not have to be the Enrollee's representative in order to make this request.

### **Assuring services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope:**

Humana uses established, nationally recognized UR criteria, and we have existing policies and procedures in place for clinical review determinations and guidelines to ensure services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope. We utilize MCG guidelines and Clinical Utilization Guidelines as well as the Commonwealth of Kentucky's rule requirements to ensure that services are medically necessary. We provide Enrollees the fullest extent of their benefits and services as specified by the Medicaid program. We refer

all requests (whether pre-service, concurrent, or retrospective) that do not meet initial medical necessity review criteria to the Medical Director for determination. **Only a Medical Director can make an adverse determination based on medical necessity.** We offer treating or ordering physicians an opportunity to discuss adverse utilization decisions with a Humana physician reviewer within the applicable timeframes after making the determination.

BH services adverse determinations are rendered by Kentucky-licensed, board-certified, or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the BH services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist licensed in Kentucky.

**Associate roles and responsibilities:** Our UM program includes both clinical and non-clinical associates who qualify based upon their education, training, licensure, and experience. We involve these associates in any decision-making that requires applying standardized clinical criteria, based on the associates' education and license, with adverse decisions only made by physicians licensed in Kentucky.

Our Kentucky-based Chief Executive Officer, Jeb Duke, Medicaid Medical Director, Dr. Lisa Galloway, MD, BH Director, Liz Stearman, CSW, MSSW, and Medicaid UM Director, Kathy Kauffmann, will have direct involvement with and oversight of UM for our Kentucky Medicaid program.

Under appropriate supervision by a registered nurse (RN) or LMHP, experienced medical professionals with an active and valid Kentucky license [e.g., licensed practical nurses (LPN)] use approved clinical decision support tools to review requests against plan benefits and established criteria. They approve services that meet criteria or medical necessity; they cannot make adverse determinations for medical necessity. Licensed physicians oversee UM decisions to facilitate consistent medical necessity determinations, in accordance with State and nationally recognized CPGs, and are the only associates qualified to make adverse determinations.

**b.x.**

How the Vendor will use its Utilization Management Committee to support Utilization Management activities.

Humana's Kentucky Medicaid UM committee considers and approves decisions related to the UM program including administrative and clinical direction, ensuring compliance with federal, State, and accreditation requirements. Reporting to the Kentucky QIC, the UM committee ensures Humana develops programs and processes, including review and development of clinical criteria used, to make UR and appeal determinations, to promote the quality of care provided to our Enrollees, and to ensure care delivered conforms with standards of care and is provided in a consistent, timely, and cost-effective manner. The UM committee is comprised of members with knowledge and responsibility of UM processes or with interdependencies related to UM functions. **Co-chaired by our Medical Director, Dr. Lisa Galloway, MD and our BH Director, Liz Stearman, CSW, MSSW,** our UM committee promotes our integrated clinical model by providing oversight of all utilization activities, including, but not limited to:

- Review and approval of any changes in UM policies, standards, and procedures, including approval and implementation of clinical guidelines and approving and monitoring the UM program description, evaluation, and work plan
- Monitoring and addressing grievances and appeals (including expedited Appeals and State Fair Hearings) related to UM activities to determine any needed policy changes
- Measuring, monitoring, and reporting utilization trends, including over- and underutilization
- Development, review, and adoption of written medical necessity criteria and procedures for applying the criteria in line with federal, State and regulatory requirements
- Evaluation of new technologies, operational, and/or clinical initiatives
- Impact of the UM program, including issues related to over- and underutilization of services
- UM policies, effectiveness of these policies, and recommendations for changes as needed

- Enrollee and provider satisfaction with the UM process
- Federal or State-required reporting specific to UM activities
- Recommendations regarding PA requirements
- Review and evaluation of physician practice patterns for quality of care and appropriateness of care
- Review of financial, utilization, and operational data related to both medical and BH activities

**Role of the UM committee in monitoring utilization trends:** The UM committee receives utilization metric trends reports during its monthly meetings. Through our UM committee meetings, we analyze indicators for identifying over- and underutilization, identify risk factors, and facilitate the development of innovative management and treatment alternatives, including specific medical management, care management and coordination, and management of chronic conditions programs, which will efficiently and effectively improve health outcomes.