2.10.4 Population Health

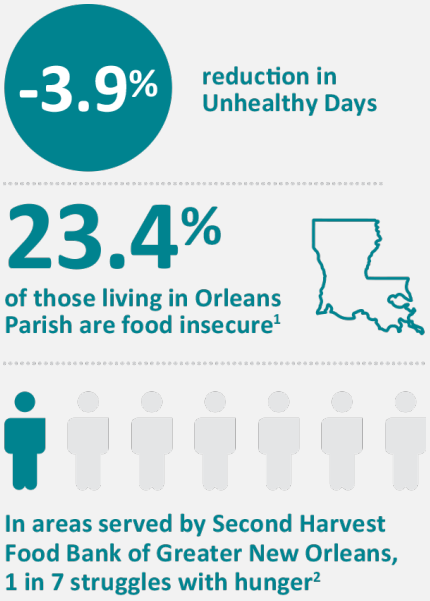
2.10.4.1 Describe its understanding and experience with improving population health for Medicaid populations

Population health is a foundational element to our enterprise mission and a core component of our managed care programs. We assess our enrollees to identify needs, employ strategies to improve the health and well-being of our enrollee population, develop and implement interventions for key sub-populations, and continuously measure and monitor outcomes to adjust our approach. Our experience serving nearly [redacted] Medicaid enrollees – combined with our 34-year presence in Louisiana – ideally positions us to expand our relationships with stakeholders, communities, and providers to further address population health priorities among Louisiana Medicaid beneficiaries.

While impacting determinants of health and well-being has been core to Humana since our founding, our focused enterprise-wide population health strategy, known as Bold Goal, began in 2015 with a commitment to develop programs and partnerships to improve the health and well-being of the communities we serve. We began this journey by selecting seven pilot communities around the country in which to drive initiatives, with the goal of applying the learnings nationwide. **Because of Humana's deep roots in the state, two of these communities are Baton Rouge and New Orleans**. We have forged working relationships with providers, non-profit organizations, and business and government leaders in both cities to co-create solutions aimed at addressing some of today's most complex health and social problems. **We have focused on implementing culturally competent initiatives that address Social Determinants of Health (SDOH) needs such as food insecurity and loneliness, recognizing that these issues have a significant impact on population health.** To measure our progress, we employ the CDC Health-Related Quality of Life measures, including Healthy Days.

Bold Goal in New Orleans

Humana Medicare Advantage (MA) enrollees living in New Orleans saw a 3.9 percent reduction in Unhealthy Days from 2015 to 2018, and MA enrollees living with diabetes showed a 6 percent decline. Enrollees also saw improvements across several priority conditions: Those living with congestive heart failure (CHF) saw a 9 percent improvement and those with Chronic Obstructive Pulmonary Disease (COPD) improved 6 percent. **Our New Orleans Health Advisory Board – a collaborative forum of more than 50 local companies, healthcare organizations, non-profits, and government groups –** has been focused on promoting physical activity and healthy eating throughout the city with their continued partnership with FitNOLA. In 2019, the group is exploring opportunities to educate and engage healthcare professionals around SDOH, including their impacts on chronic conditions such as diabetes and depression. They are also working with the American Heart Association (AHA) to build health literacy and advocacy programs in one of New Orleans' most underserved neighborhoods.



[1]map.feedingamerica.org/county/2015/overall/louisiana/county/orleans
[2]www.feedingamerica.org/find-your-local-foodbank/second-harvest-foodbank-of-greater-new-orleans-and-acadiana

As we take our learnings from our pilot communities and expand Bold Goal nationwide, improving population health remains at the center of our approach to serving our enrollees and communities. This includes taking a holistic view to health and integrating physical, behavioral, environmental, and social factors into our clinical interventions to advance health equity and outcomes. **To ensure that population health is at the forefront of the operations and strategic leadership of our Louisiana Medicaid plan, we will employ a Louisiana Chief Population Health Officer (CPHO) who will report directly to our plan CEO**. This leader, who will sit alongside our Louisiana Medicaid CMO and Behavioral Health Medical Director (BH MD), will bring backgrounds in both healthcare and public health. The CPHO will supervise a local senior-level executive Culture and Community Engagement Director, who will develop and implement strategic partnerships and interventions to address SDOH and health equity within the context of our model of care.

Our approach to improving the health of the Louisiana Medicaid population (depicted in Figure 2.10.4.1-A) has been built from our longstanding presence in Louisiana, as well as our experience serving similar populations through our other Medicaid plans. It includes the following key elements:

- Embedding population health strategies throughout our plan operations to improve health outcomes and promote smarter spending
- Employing dedicated community engagement associates and Community Health Workers (CHWs) to build relationships with community partners and address the needs of individual enrollees
- Integrating population health priorities into our quality management program to inform improvements in care delivery and outcomes, including advancing health equity
- Addressing SDOH as critical gaps in care and integrating them as part of Humana's comprehensive and integrated model of care
- Building and maintaining sustainable, strategic relationships with community partners, state agencies, and providers to create evidence-based, scalable, and financially sustainable population health solutions

2.10.4.1.1 Identifying baseline health outcome measures and targets for health improvement

Our chosen population health metrics, drawn from Attachment G of the RFP, as well as other external (e.g., Healthcare Effectiveness Information Data Set (HEDIS)) and internal (e.g., disease management outcomes) sources, emphasize the three types of prevention as defined by the CDC. Metrics for each prevention type include:

- **Primary** (intervening before health effects occur): Immunization rates, tobacco cessation, and SDOH prevalence
- **Secondary prevention** (screening to identify diseases in the earliest stages): Cancer and diabetes screenings
- **Tertiary prevention** (managing disease post-diagnosis to slow or stop disease progression): HIV viral load suppression and completion of Hepatitis C antiviral treatment

We will analyze the below data sources to identify potential areas for improvement. **As data is captured in a centralized data ecosystem, we establish baselines and use tracking tools and dashboards for regular reporting**. In addition to traditional metric tracking, **Humana also applies advanced analytic capabilities to the data ecosystem in order to create enrollee segmentation and predictive models** that provide a deeper understanding of our enrollee population and enable us to predict and prevent future events and progression of disease. We rely on the following data sources to establish baselines and targets for health improvement for each metric:

- HEDIS: We use HEDIS data to understand the current baseline health of the population and to establish targets using percentile data at the state, regional, and national levels.

- State data: In Louisiana, we will use LDH's State Health Improvement Plan and the Louisiana Health Report Cards to establish baselines for preventive care, screening, and treatment rates (among other measures). We will also compare statewide rates to national and regional averages to inform our targets for health improvement.
- Claims and utilization data: Claims and utilization data can give us a more granular insight into enrollee behavior and allow us to set utilization baselines across different population characteristics (e.g., age, gender, and race). We collect this information through submitted physical health, behavioral health (BH), and pharmacy claims and encounters; admission, discharge, and transfer data; laboratory data; and Health Information Exchange (HIE) data. To set targets for utilization we review published data, consult national guidelines on condition management, and rely on the input and expertise of Humana's clinicians.
- Proactive outreach to enrollees: We will collect health and SDOH data about our enrollees through new enrollee welcome calls, Health Needs Assessments (HNAs), Healthy Days telephonic surveys (more information included below), Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and post-discharge calls. These data sources supplement the enrollee data available through claims and encounters, particularly for new enrollees with limited historical information.

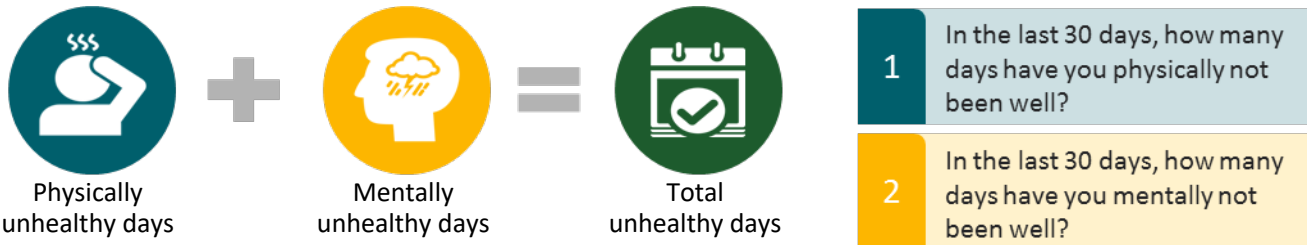
2.10.4.1.2 Measuring population health status and identification of sub-populations within the population

Measuring Population Health Status

In accordance with Section 2.6.1.2.2 of the Model Contract, Humana's Population Health Strategic Plan will include a strategy for measuring population health status and outcomes. It will leverage existing public information from the State as well as our own data analysis of enrollees. Humana's approach to measuring population health status seeks to monitor, track, and trend key indicators of clinical outcomes across the entirety of our enrollee population. These indicators give us a holistic view of the health of our enrollees and allow us to drill down deeper to identify specific needs of sub-populations. We establish and track health outcome measures in four main categories:

1. Clinical outcomes: Measured in numerous clinical and clinical quality measures (HEDIS, National Committee for Quality Assurance (NCQA), and National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), 3M potentially preventable events (PPEs))
2. Healthcare resource utilization and cost of care: Measured in emergency department (ED) visits, admissions, and readmissions, as well as physical health, BH, and pharmacy costs
3. SDOH: Measuring SDOH such as food insecurity, homelessness, physical safety, loneliness, transportation insecurity
4. Health-Related Quality of Life: Measured in Healthy Days (depicted in Figure 2.10.4.1.2-A) and enrollee satisfaction

Figure 2.10.4.1.2-A – CDC Healthy Days Metric



Humana builds data into operational metrics dashboards to track and trend population health. Dashboards allow us to follow trends over time or drill down to specific segments of populations and time periods to closely monitor outcomes of particular sub-populations. We also use business intelligence tools that support our quality teams in stratifying outcomes by race and ethnicity as well as a dedicated Quality Analytics team to deliver ad-hoc reports and analyses as needed. **We incorporate feedback from our Enrollee and Provider Advisory Councils (PACs) in our root cause analyses (RCA) processes, soliciting input from both enrollees and providers to better understand the dynamics that may contribute to health disparities**.

The following proprietary tools synthesize these metrics to identify characteristics and needs of the population:

- [redacted]

[redacted]

Identification of Sub-Populations

We use numerous strategies to identify those sub-populations named in Section 2.6.2.2.1 of the Model Contract, including sub-populations experiencing a disparate level of needs such as housing, food insecurity, physical safety, and transportation; sub-populations demonstrating disparate levels of poor health outcomes or access issues based on factors such as geographic location, age, ethnicity, race, gender identity, sexual orientation, religion, primary language, disability status, and income level; and enrollees with special health care needs (SHCN).

As a first step, we establish the populations and sub-populations that we want to measure and track, including:

[redacted]

We then use various tools and methods to gather information and identify members of sub-populations, including:

- Health Needs Assessment: This self-reporting data tool allows for analysis at the total population level across the continuum of health, from diet and exercise levels, to risky and unhealthy behaviors, and chronic condition management and SDOH priority issues. In addition, the HNA will be a key data source for the identification of key sub-populations, including enrollees with SHCN and enrollees with unmet SDOH needs.
- Claims Analysis and Risk Scoring: Humana has several proprietary sub-population identification and risk-scoring methodologies, including the Early Indicator Report (EIR), Opioid Predictive Model, Medicaid Severity Score Predictive Model, the Readmission Predictive Model, and the ED Predictive Risk Model (further described in our response to Section 2.10.5 of the RFP). Within the Humana Office of Population Health, we have also developed analytic techniques to segment, predict, and engage enrollees with specific SDOH needs.
- Clinical Data: We use data obtained from direct connections built with almost all of the leading electronic health record (EHR) software systems (including Allscripts, eClinicalWorks, and Athena Health), as well as multiple state HIEs, to gain insight into our enrollees' provider interactions and capture information on enrollee diagnoses, gaps in care, labs, medications, and needs that is traditionally available only through chart audits.
- Provider Referrals: Through our Provider Relations (PR) representatives and CHWs, we actively seek to educate providers on our case management offerings, particularly for enrollees with SHCN.
- Enrollee Self-Referrals: Maintaining a "no wrong door" policy, we will include directions in our Enrollee Handbook, Welcome Call, and other enrollee communications on how to self-refer for case management and SDOH support.
- [redacted]

[redacted]

2.10.4.1.3 Identifying key determinants of health outcomes/strategies for targeted interventions to reduce disparities

Identifying key determinants of health outcomes

Our CPHO – in partnership with our Chief Medical Officer (CMO), BH MD, and our national enterprise Director of Population Health, Dr. Andrew Renda – will oversee the design and implementation of programs to address key determinants of health outcomes. Our population health analytics team uses the tools and data sources described above to identify trends and their links to health outcomes. We regularly incorporate external sets of data (e.g., census data) into our models to identify population-wide trends and determine how they apply to our own enrollee population. At the tract or block numbering group level, census data provides views of neighborhoods with a high concentration of a given racial or ethnic group. When compared against health outcomes data from the same geography, we can identify the effect of racial and ethnic disparities on the health of the population.

Our process, in alignment with this approach and Subsection 2.6.1.2.2 of the Model Contract, uses a rapid cycle quality improvement methodology to identify key determinants of health outcomes. This includes (1) monitoring system-wide issues, (2) identifying opportunities, (3) determining the root cause of problems identified, (4) exploring alternatives and developing an action plan, and (5) activating the plan, measuring the results, evaluating effectiveness of actions, and modifying as needed. Humana considers RCA a crucial part of our quality improvement process, allowing us to fully understand and to create a targeted solution to resolve an issue and prevent recurrence. As part of our RCA process, we analyze trends and data based on geographic and demographic data, stratifying outcomes by race, ethnicity, language spoken, gender identity, ZIP code, disability status, and other population characteristics.

Strategies for targeted interventions to reduce disparities

Health Promotion and Disease Prevention

We are focused on creating personal, simple, and connected experiences to help enrollees and their families understand how to successfully navigate the healthcare system and make educated decisions to improve their health outcomes. We inform our education efforts by developing a deep understanding of the communities we serve, including health disparities, maintaining a 360-degree view of our enrollees, [redacted] For Louisiana Medicaid enrollees, our Go365 engagement application will apply behavioral economics theory and actuarial science to link near real-time rewards with the completion of healthy behaviors.

Proactive Enrollee Messaging: We use our clinical rules engine, Transcend Insights, and predictive algorithms built around our clinical technology platform, CareHub, to develop targeted clinical messaging for our enrollees. Our Customer Relationship Management (CRM) tool integrates CareHub data to personalize our enrollee messages to include topics most relevant to them and to stay aware of what other communications they have received. We can then use the CareHub information to prioritize an enrollee's health needs so that CRM can send personalized messages via text messaging, our enrollee portal, or during communication with a Customer Care Specialist in a sequence that aligns with the urgency of those needs. For example, if an enrollee's A1C level is high, we prioritize messaging to address their blood sugar, followed by additional, planned reminders to schedule an eye exam appointment through our vision value-added benefit (VAB). [redacted]

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Outreach: Recognizing the importance of EPSDT for our Medicaid population, Humana has instituted specialized outreach tools to connect with the parents and guardians of our enrollees under age 21. Upon identification of a care gap for an enrollee, we provide enrollee mailings and outbound calls to assist with appointment scheduling. [redacted] To further increase access

and close care gaps, [redacted] We will also offer provider incentives for completion of recommended well-child and adolescent well-care visits.

Community Engagement: Under the direction of the CPHO and Culture and Community Engagement Director, our Louisiana Medicaid Community Engagement team will identify, design, and implement community engagement programming that is responsive to enrollee needs, takes into account health disparities, and leverages our relationships with community-based organizations (CBOs), faith-based organizations, [redacted]. **Our five existing Humana Neighborhood Locations in Baton Rouge, Lafayette, Lake Charles, Metairie, and Shreveport** [redacted] **provide further opportunity to implement innovative events** for our Medicaid enrollee population, including healthy cooking demonstrations, nutrition classes, fitness classes, and Baby Showers for expectant mothers.

Our national Bold Goal initiative has taught us a great deal about the role that race and ethnicity play in health disparities. According to the city of San Antonio Metropolitan Health District, racial minorities are more likely to be diagnosed with diabetes. The San Antonio Health Advisory Board, which is part of our Bold Goal initiative, partnered with the American Diabetes Association and Humana to launch an online Diabetes Resource Guide. The Guide, which launched in May 2017, is an inventory of free and low-cost programs and services for people living with or at risk for diabetes and their caretakers. Using focus groups, including Humana's Hispanic Network Resource Group Unidos, we tested the site to ensure it was easy to use and accessible. Humana translated the resources and information available through the Guide into Spanish and engaged in a comprehensive effort to educate local physicians about the Guide. [redacted]

Disease Management (DM)

Our targeted DM interventions apply an enrollee-centric model focused on behavioral change and condition self-management. Through the predictive models described above, we will differentiate between those enrollees who will benefit from our case management interventions (as described in our response to Section 2.10.5 of the RFP) and those enrollees who require additional assistance to manage a chronic condition through our DM programs. **In developing our DM interventions, we took into consideration LDH's selected population health priorities (as defined in Section 2.6.1.1 of the Model Contract), disease prevalence among the Louisiana Medicaid population, and feedback from our community-based partners on the conditions that they find to have the largest impact on the population they serve.** [redacted]

[redacted]

Humana's Louisiana Medicaid DM programs include:

- Acquired and congenital heart failure
- ADHD
- Asthma/COPD
- Depression and PTSD
- Diabetes
- Hepatitis C treatment
- HIV/AIDS
- Hypertension
- Sickle Cell Disease
- Substance use disorder, including opioid use disorder

In addition to our formal DM programs, we will implement other disease-specific approaches to respond to those priorities identified by LDH and other trends that we note in our Louisiana Medicaid membership. These include:

Tobacco cessation: We recognize that smoking rates in Louisiana are disproportionately high among young people; according to the CDC, 12 percent of high school students in Louisiana smoke (exceeding the national average of 9 percent), and individuals ages 18-24 have the highest smoking rates among adults. In addition, one out of 8 Louisiana high school students regularly uses e-cigarettes, according to the Louisiana Youth Tobacco Survey. To address this disparity in age groups, Humana will offer our **value-added tobacco cessation benefits** (further described in our response to Section 2.10.3 of the RFP) to enrollees ages 12 and older.

Obesity: To respond to the high rates of obesity in Louisiana – where more than one in three adults is obese, according to CDC data – we will offer all enrollees aged 18 and older **health coaching services** to promote weight management. We will also offer a discounted YMCA membership as an added benefit to promote physical activity.

Syphilis: According to the CDC, Louisiana ranks first among U.S. states for congenital syphilis case rates and third for primary and secondary syphilis case rates. LDH data indicates that syphilis rates among African Americans are almost four times higher than rates among whites and Hispanics. To target congenital syphilis rates, Humana will educate all pregnant enrollees about syphilis through our MomsFirst maternity case management program (described below) and our pregnancy-related educational materials. In addition, **we will offer our OB/GYNs an incentive for syphilis screening during the third trimester**. To reduce primary and secondary syphilis case rates, our Community Engagement team, led by our Culture and Community Engagement Director, will explore opportunities to partner with the OPH, providers, and local Parish health units on sexually transmitted disease (STD) screening initiatives and campaigns that target the age groups, races, and geographic areas with the highest rates of syphilis infection.

Early childhood health and development, including adverse childhood experiences (ACE): Our Maternal Child Health/EPSDT Coordinator will collaborate with our CPHO to develop population health solutions to address early childhood health and development. We plan to partner with providers of early childhood services (such as Kinsley House) to provide wraparound SDOH supports and mitigate the impacts of poverty on child development. We will also include a question in our comprehensive case management assessment to **address the effect that ACEs have on our enrollees of any age** and will look for opportunities to include content on ACEs in our online provider trainings on childhood behavioral health. In addition, our Provider Services department (in collaboration with our Maternal Child Health/EPSDT Coordinator) is responsible for ensuring that our network is compliant with EPSDT requirements, including conducting the recommended developmental screenings. We will also educate our network providers on the availability of early childhood services, including Head Start and EarlySteps, to promote appropriate referrals.

Infant mortality: Humana is committed to reducing Louisiana's preterm birth rate, including addressing the associated health disparities. According to the March of Dimes, the preterm birth rate among the African American population is 1.34 times higher than the average rate among all other groups.

[redacted]

Maternal morbidity and mortality: Our MomsFirst program provides maternity case management services for all pregnant enrollees, with contact frequencies and modalities targeted to the enrollee's acuity level. In tailoring our MomsFirst program for Louisiana, we will take into account how age, race, ethnicity, and geographic area affect maternity outcomes. According to LDH's Maternal Mortality Review Report, 68% of maternal deaths between 2011 and 2016 occurred among African-American Louisianans.

- [redacted]

- [redacted]

- *Humana Storks:* Through our Humana Storks program, piloted at two hospitals in South Florida, Humana associates greet new mothers in the hospital with a care package and information about how to access important health services for themselves and their infants, including postpartum and well-child visits. [redacted] Humana intends to replicate the success of this program in Louisiana. We will review claims and outcome data to identify and target high-volume hospitals that serve enrollees with lower rates of postpartum visit or well-child visit completion.

Social Determinants of Health

Through Humana's experience working with Medicaid enrollees, we are keenly aware of how proactively addressing SDOH needs leads to improved health outcomes. We will deploy robust SDOH interventions to address the SDOH needs present in the Louisiana population. Our **Comprehensive Care Support (CCS) team** – including our Case Managers (CMs), CHWs, and peer support specialists, our SDOH Coordinators, and our Housing Specialists, among others – will conduct outreach and engage with enrollees, including those not in case management, to respond to the unique SDOH need(s) as identified by the HNA, referrals, and the data mining methods described above. [redacted] As detailed below, Humana has established a number of innovative, evidence-based partnerships with CBOs to address LDH's SDOH priority areas for Louisiana Medicaid.

"Humana's commitment to homeless diversion and medical respite care will provide a much-needed resource throughout New Orleans."
– Cashuana Hill, Executive Director, Greater New Orleans Fair Housing Action Center

[redacted]

Housing Insecurity: Humana will use HNA, enrollment data, and referrals to identify and reach out to enrollees with housing insecurity to connect them with our housing specialists for support. We will partner with agencies directly serving the homeless population to facilitate access to immediate and long-term housing solutions. As described in our response to Section 2.10.3.2 of the RFP, we are also exploring innovative financing options to expand respite care bed capacity for homeless enrollees in Louisiana [redacted]

Food Insecurity: We recognize that food insecurity can exacerbate chronic disease, complicate pregnancies, and lead to poor school performance, behavioral issues, and impaired growth and development. To combat food insecurity, our CCS team actively supports enrollees' access to food security programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Supplemental Nutritional Assistance Program (SNAP), but we recognize not all enrollees qualify for these programs or may still require additional food supports. To augment these important programs, we maintain a robust network of national and local food resources to address enrollee food insecurity needs, including a national partnership with **Feeding America**. [redacted] ur partnership with Feeding America has also produced our **Food Insecurity Toolkit** that provides food insecurity resources for providers, CBOs, and government organizations. As an added benefit, we will offer our delivered meals to our enrollees who are engaged in transitional case management or who have a CM-identified food insecurity need.

Physical Safety: Through the HNA, we will assess the physical safety of enrollees to determine any resources or support needed. Our CCS team will have resources at their disposal to address the range of physical safety issues that can affect our enrollees, including supports for domestic violence, self-harm, child abuse, and natural disasters. In the event of a natural disaster, we leverage geographic data to identify enrollees in flood and hurricane evacuation zones and reach out to provide assistance. Our CCS team can also help enrollees develop a disaster plan, including where they can go in the event of a disaster and supplies to pack (e.g., prescription medications and potable water).

Transportation: Limited access to transportation can have significant impacts on our enrollees' ability to access vital services. When our CMs or SDOH Coordinators identify an enrollee who requires transportation assistance to reach a needed SDOH service – such as legal assistance to avoid eviction or a food bank – they can arrange transportation through our non-emergency medical transportation (NEMT) vendor, [redacted], to address the SDOH need at no cost to the enrollee. This added benefit supplements covered NEMT services for healthcare-related appointments.

Education & Employment: As a VAB, Humana will partner with **GEDWorks™** to offer eligible enrollees without a high school diploma the opportunity to receive test preparation assistance and have their GED exam covered at no cost. Using the Humana-United Way CRD, we will connect enrollees to employment supports, including vocational rehabilitation and the Louisiana Workforce Commission. Humana will also help enrollees arrange proper supports, such as child care assistance through the Child Care Assistance Program, to maintain employment.

2.10.4.1.4 How required components are integrated, representing a comprehensive approach to population health

Our Louisiana Medicaid CPHO will not only drive our Population Health Strategic Plan and our relationships with LDH, OPH, and other state and local government agencies (along with Louisiana CBOs), but they will also **ensure integration and collaboration across all of our Louisiana lines of business and with new and ongoing Bold Goal efforts in Baton Rouge and New Orleans**. The CPHO will be a voting member of our Quality Assessment Performance Improvement (QAPI) committee, ensuring that Humana addresses population health in its quality initiatives and overall strategy. While our CPHO drives strategies and plan-wide efforts to address population health, our CCS team leads on-the-ground efforts to address the needs of individual enrollees. In alignment with Section 2.6.3.2.3 of the Model Contract, Humana will deploy CHWs as part of our CCS team across the state. We will employ CHWs who are from the communities in which they work, providing critical feet-on-the-street assistance with finding, engaging, and coordinating physical health, BH, and SDOH services for enrollees and working in alignment with our provider community, CMs, and CBOs. **We will also deploy local SDOH Coordinators within each CCS team throughout Louisiana.** They will be responsible for establishing and maintaining relationships with local CBOs and communicating

details to the rest of the CCS team to ensure appropriate access to needed services. Our CPHO and CMO will work together to ensure the highest degree of integration between Humana's clinical programs and the plan-wide initiatives and partnerships spearheaded by the CPHO, including the development of a mechanism for regular feedback and information-sharing with our SDOH Coordinators to link local efforts with statewide priorities.

Humana uses CareHub, our internal and proprietary integrated set of tools, to monitor and track health outcomes and utilization for enrollee populations. To supply clinicians with a holistic view of the enrollee, CareHub integrates enrollee data from a variety of sources including claims, HNA, biometrics, personal health profiles, lab tests, and results through our integrated clinical platform, Clinical Guidance eXchange (CGX). **As a fully-integrated platform, CareHub supplies enhanced capabilities to our CCS team** to identify candidates for programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention.

To support population health management at the provider level, **we maintain a provider population health management platform that draws on CareHub data to provide an integrated view of gaps in care, services, and needs across the provider's patient panel**. **In addition, we will employ value-based payment (VBP) and support the collection of electronic quality measures (in line with the Louisiana Health Information Technology Roadmap) to encourage and help our providers in addressing SDOH needs and applying clinical best practices.** We have experienced firsthand the potential of VBP to improve population health. [redacted] Through investments in the employment of CMs and social workers and using the care gap data provided by Humana, our full-risk providers are equipped to help address the SDOH that affect our enrollees' outcomes and care utilization.

2.10.4.1.5 Other considerations the Proposer may seek to present

As described in the two examples below, we are committed to collaborating with other payers, CBOs, and providers to implement innovative population health initiatives. We are eager to explore similar opportunities in Louisiana.

- [redacted]
- As part of Humana's Bold Goal Population Health Strategy, Humana is exploring the development of a referral [redacted]

2.10.4.2 Addressing population health in the first year of the Contract, including milestones and timeframes

The following table illustrates content, milestones, and timeframes for our population health plan in year one.

Table 2.10.4.2-A: Humana's Louisiana Medicaid Year One Population Health Strategic Plan

Model Contract Requirement	Milestone	Timeframe
2.6.1.1: Population Health Strategic Plan	Submit Humana's Population Health Strategic Plan to LDH	Mar 1, 2020
2.6.1.2.1: Identification of sub-populations within the enrollee population for prevention and programs	Implement LDH's HNA and Humana's comprehensive assessments for physical health, BH, and social needs	Jan-Dec 2020
	Run predictive models for risk stratification of sub-populations	Jan-Dec 2020
	Educate enrollees, providers, and CBOs on enrollee referrals	Jan-Dec 2020

Table 2.10.4.2-A: Humana's Louisiana Medicaid Year One Population Health Strategic Plan		
Model Contract Requirement	Milestone	Timeframe
2.6.1.2.2: Measuring population health status and outcomes – identify baseline measures and targets to include quality measures	Establish baseline reporting and set improvement targets	Apr-Aug 2020
	Develop LDH-mandated quality measures with Triple Aim population health dashboard	Jan-Jun 2020
	Initiate reporting on LDH-mandated quality measures with Triple Aim population health dashboard and Healthy Days metrics	Jul-Dec 2020
	Implement rapid-cycle quality improvement processes	Jul-Dec 2020
2.6.1.2.3: Identify health promotion and disease prevention programs based on specific needs	Develop customized wellness and health prevention programs based on identified population health disparities	Jul-Dec 2020
	Develop engagement strategies for wellness and prevention programs	Jul-Dec 2020
2.6.1.2.4: Identify key determinants of Disease Management and priority health outcomes and strategies for targeted interventions to address determinants	Identify health disparities and chronic disease drivers to inform development of evidence-based and culturally competent DM programs	Jul-Dec 2020
	Implement evidence-based interventions that target identified health disparities and chronic health drivers	Jul-Dec 2020
	Submit updates (at minimum) to LDH and network providers on effectiveness of population health/case management initiatives	June 2020 & Dec 2020
	Identify community resource gaps to expand our CBO network and inform United Way's CRD through our partnership	Jan-Dec 2020
2.6.1.2.5: Incorporate community-based health and wellness strategies through promotion of LDH public health programs and collaboration with CBOs	Implement standardized evaluation process of HNA responses to consistently identify SDOH needs across the population	Jan-Dec 2020
	Use CHWs to engage enrollees, collaborate with CBOs, address SDOH needs, and support linkages to CBOs and health and wellness programs	Jan-Dec 2020
2.6.1.2.6: Promote enrollee engagement and input into population health programming	Implement culturally appropriate, targeted engagement strategies for enrollees	Apr-Dec 2020
	Initiate interventions in partnership with providers, CBOs, and public agencies	May-Dec 2020
2.6.1.2.7: Working with CBOs and OPH to address at least one specific initiative	Work with CBOs and OPH to identify initiatives to improve overall enrollee health, based on reviews of existing community HNAs	Jan-Mar 2020
	Develop at least one initiative (in conjunction with CBOs/OPH) to improve overall health of enrollees and address health inequities	Apr-Jun 2020
	Deploy and measure the impact of targeted intervention(s) in addressing discrete health inequities experienced by sub-populations	Jun-Dec 2020

2.10.4.3 Describe Proposer's recent experience utilizing data regarding SDOH to improve health status

Issue identification: An evaluation by our population health analytics team revealed that Humana enrollees with food insecurity were almost **twice as likely to have poor health outcomes** and almost **four times as likely to be disabled,** Humana chose to dive deeper into this issue in our Florida Medicaid market to refine our approach to this issue.

Interventions: In partnership with Feeding South Florida, **we screened more than 4,000 patients** for food insecurity in three primary care clinics (based on practice affiliation, not just Humana membership). Patients who screened positive received a referral from the clinician to meet with an on-site Feeding South Florida representative, who connected the patients with programs like SNAP and offered them an emergency box of food.

Assessment of impacts: **Approximately 1,400 patients screened positive** and agreed to enroll in the study. Roughly two-thirds of patients were placed in the intervention group, which received case management, education, and support in accessing healthy foods through community resources. About one-third of the patients were placed in the control group, which also received information about community resources but without the oversight and case management that the intervention group received.

Outcomes: While we are still analyzing outcomes of this study, our preliminary findings indicate that **food insecure patients had nearly twice as many Unhealthy Days each month** and that transportation is important in helping

patients get the food they need. To build upon this study, Humana has launched a larger, randomized control trial to demonstrate that applying a high-touch intervention to address food insecurity positively impacts health outcomes.

Application to a population health priority: Food insecurity has a demonstrated link with obesity. This study has demonstrated the importance of case management and ongoing support in resolving food insecurity among a Medicaid population. Therefore, an important aspect of our approach to obesity in Louisiana will be our SDOH Coordinators, who can provide hands-on, case management-type support to enrollees with food insecurity needs.

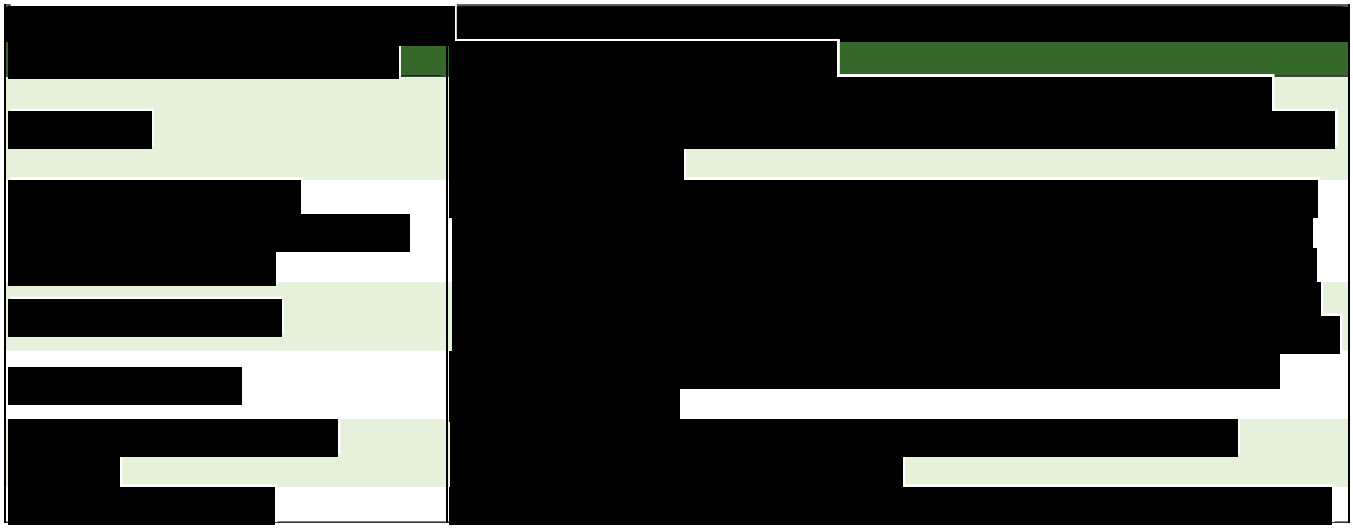
2.10.4.4 Approach to contracting with CBOs and OPH to coordinate population health improvement strategies

Contracting with CBOs

From large national organizations like Feeding America and [redacted] umana has a demonstrated history and goal of recognizing the value and assets of CBOs while not replicating or duplicating services and offerings. We work to not only enhance the services we provide for our enrollees, but to also expand the capabilities and capacity of CBOs, recognizing the important work they do as well as the potential they may have to deploy additional resources.

"Humana's SDOH interventions will support Kingsley House in achieving the goal of providing comprehensive resources to aid families in achieving intergenerational self-sufficiency." – Keith Liederman, Ph.D., CEO, Kingsley House

Under the leadership of our CPHO and Culture and Community Engagement Director, our approach to contracting with CBOs for population health improvement strategies will adhere to Section 2.6.3.2 of the Model Contract. We have developed plans for communicating and coordinating services and have discussed mutual data sharing and reporting with organizations like the [redacted] and Kingsley House. [redacted]



Contracting with OPH

Our methods of contracting with OPH will mirror the approach used to contract with CBOs, taking into account OPH's position as a government agency and its unique offerings, including the role that local Parish health units play in the care delivery system. As a board member for the Taking Aim at Cancer in Louisiana initiative and a participating WellSpot, Humana is already an active participant in OPH's initiatives. Under the leadership of our Louisiana Medicaid CPHO, Humana will share data and analytics with OPH to create a goals framework, advance a population health needs assessment, and facilitate a potential community-based return on investment analysis. We will work with OPH to create a "best practice" forum that focuses on designing and implementing interventions to improve population health measures.