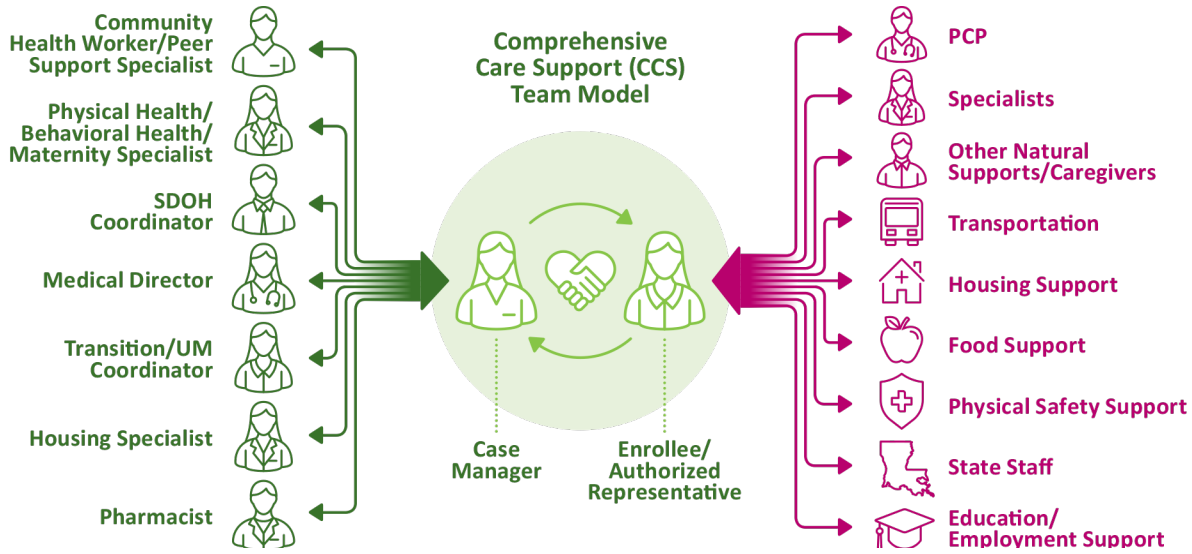
2.10.5 Care Management

Across our Medicaid plans, we engage [redacted] in our case management programs through telephone and face-to-face outreach. We also serve [redacted] Louisianans today across our various lines of business and in [redacted]. In alignment with our population health commitment to deliver approaches that meet the needs of the wide variety of individuals we serve, our integrated case management program serves the diverse and often complex physical health, behavioral health (BH), and social determinants of health (SDOH) needs of our highest-risk Medicaid enrollees.

Our fully integrated Comprehensive Care Support (CCS) team anchors our Louisiana Medicaid case management program. The CCS team provides a forum for our associates with expertise in the physical health, BH, and SDOH needs of Medicaid beneficiaries 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 all their care needs and remain with the same case manager (CM) as their needs change. Figure 2.10.5 illustrates our CCS team model below.

Figure 2.10.5 – Comprehensive Care Support (CCS) Team Model



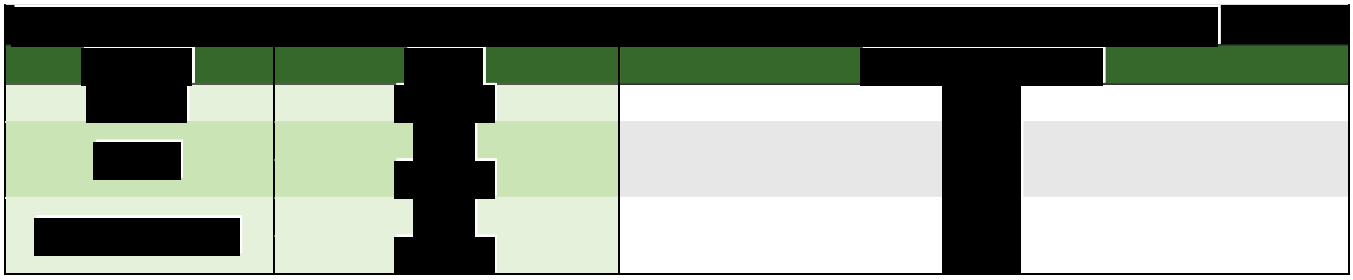
Over the last several years, we have made significant investments in our integrated clinical platform, Clinical Guidance eXchange (CGX), to support the efficient delivery and coordination of covered services. CGX's functionality enables direct management of BH, social, and physical health services, enhancing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

Our approach to case management is also rooted in strong partnerships with network providers, State agencies, and community-based organizations (CBO). We recognize that many of our enrollees with complex needs, including those with severe and persistent mental illness (SPMI), often have strong, established relationships with their care providers. Rather than disrupt these relationships with our own personnel, **we have designed our CM structure to incorporate and support existing case management services through robust data-sharing** via our provider portal and population health platform, regular multi-disciplinary care team (MDT) meetings, and development of streamlined provider communication lines. In addition, we will promote innovative methods of coordination with provider- and agency-led case management in Louisiana, [redacted]

Our case management approach has improved patient outcomes, reduced costs, and supported self-management of chronic conditions among Medicaid enrollees. Our achievements include:

- [redacted]
- [redacted]

[redacted]



2.10.5.1.1 The Proposer's process for ensuring that there is success in completing enrollee health needs assessment (HNA) within the required time periods;

Humana's Health Needs Assessment (HNA) process will comply with Section 2.7.2 of the Model Contract and all applicable requirements captured in the MCO manual. **We will make a minimum of 6 HNA completion attempts for all enrollees. This exceeds the contractual requirement to make at least 3 efforts to complete the HNA at different days and times.** Recognizing the diverse needs, preferences, and locations of our Medicaid membership, we offer **6 avenues** for HNA completion: via telephone, via mail, in-person, online through Humana's enrollee portal, via a smartphone application, or through network providers.

We take a proactive approach to HNA completion, including the following outreach:

- Mail: Upon enrollment, all new enrollees will receive a copy of the HNA in their welcome packet, along with a pre-addressed envelope with return postage. The welcome packet also includes a welcome letter; the member identification (ID) card; phone numbers for the Nurse Advice Line (NAL), our [redacted] BH Crisis Line [redacted], and our Louisiana-based Customer Care; a Continuity of Care form; and a Release of Information agreement.
- Outbound Calls: Humana will make 3 attempts to reach each new Humana enrollee by telephone within the first 30 calendar days of enrollment, surpassing contractual requirements. Calls will occur on different days of the week and at different times of the day to maximize the likelihood that we successfully connect with an enrollee. After the second unsuccessful phone attempt for the HNA, we will send the enrollee a HIPAA-compliant postcard in the mail requesting a callback. If we have been unable to contact the enrollee within the first 30 days, we will make at least 1 more outbound call attempt in both the second and third months after enrollment.
- In-Person: If our first 3 telephone attempts and our mailing attempts to reach an enrollee with special health care needs (SHCN) have been unsuccessful, we will conduct research and in-person outreach to locate the enrollee and complete the HNA. [redacted]

Our HNA completion efforts are not limited to these formal attempts, as we consistently look for opportunities to reach our enrollees and promote HNA completion. These include:

- Inbound calls and visits to Humana neighborhood locations: Our Customer Relationship Management (CRM) system will alert our Customer Care Specialists when an enrollee with an uncompleted HNA contacts Humana's Customer Care or visits a Humana Neighborhood location. The Customer Care Specialist can help the enrollee complete the HNA by telephone; [redacted] or complete it in person at a Humana neighborhood location.
- Transitional case management: HNAs will be completed as part of the transition planning process for enrollees who are moving between care settings and are engaged in transitional case management (see Table 2.10.5.1.1 - B below).

- Online: Enrollees using our enrollee portal, Go365 smartphone application, and [redacted] non-emergency medical transportation (NEMT) smartphone application will receive alerts and push notifications directing them to complete the HNA.
- Provider visits: We will furnish our network providers with copies of the HNA and educate them on the importance of HNA completion, how to assist enrollees to complete the HNA, and how to return completed HNAs.

To encourage enrollees to complete the HNA, we will provide a [redacted] incentive for completion within the first 90 days of enrollment. Enrollees who complete the HNA after the first 90 days of enrollment will receive an incentive of [redacted] All enrollees are eligible for this incentive.

Unable to Contact (UTC) Process

Our efforts to complete the HNA for an individual enrollee will not end after the initial completion period has passed. After 90 days with no successful contacts, we will designate the enrollee as unable to contact (UTC). We then forward the enrollee's file to our UTC queue within CGX for our UTC specialists to manage.

Our UTC approach will leverage data mining techniques and our Louisiana relationships to successfully locate and engage difficult-to-reach enrollees. These methods include:

- Locating updated contact information through the following data sources:
  - Claims data, including pharmacy data
  - Information collected during discharge planning
  - Clinical data feeds from participating providers, including Ochsner Health System facilities
  - Health Information Exchange (HIE) feeds
  - Online search engines (e.g., LexisNexis) to access government records, including death certificates and correctional facility admissions
  - Reports of updated contact information from our strategic partners that provide NAL, BH Crisis Line, NEMT, and case management services
- Contacting assigned primary care providers (PCPs), pharmacies, and homeless shelters to determine if they have obtained updated or alternative contact information

In line with our commitment to continuous quality improvement, we will periodically evaluate and refine our outreach process to increase HNA completion rates with the support of Humana's behavioral economics team. We will assess differences in completion rates among enrollee cohorts, including different geographic locations, age groups, races and ethnicities, language preferences, and eligibility categories, and tailor our interventions appropriately. Our Medicaid plan in Florida undertook a similar process to increase HNA completion rates for several key population groups, including enrollees with SPMI, asthma, and diabetes, and enrollees who are pregnant. Through the implementation of focused call campaigns, including authorization of additional associate work hours to complete calls in the evenings and on weekends, our plan surpassed state benchmarks for these key populations. The success of this program has a direct bearing on our planned Louisiana HNA completion efforts; noting that we reached the highest percentage of enrollees during the fourth outbound call attempt, we will complete a minimum of 5 call attempts (plus 1 mail attempt) for all enrollees, in addition to our other outreach efforts. We have summarized the results of our Florida HNA initiative in Table 2.10.5.1.1 - B.

[redacted]

2.10.5.1.2 How the Proposer will utilize predictive modeling, referrals and the HNA process to identify individuals who can potentially benefit from case management;

Humana maintains a "No Wrong Door" policy to identify enrollees who may benefit from case management. We identify enrollees both at the time of enrollment and on an ongoing basis using a multi-faceted approach, including but not limited to our proprietary predictive models, internal and external referrals, and the HNA process.

Predictive Models

[redacted]. By applying these 3 models in tandem, [redacted] In compliance with Sections 2.7.3.2 and 3.1.9.1.8.3 of the Model Contract, we will submit our predictive model methodology to LDH for review and approval.

- [redacted]
  - *Methodology*: [redacted]
- [redacted]
  - *Methodology*: [redacted]
- [redacted]
  - [redacted]

Referral Pathways

In compliance with Section 2.7.5.2 of the Model Contract, Humana will consider all referred enrollees for engagement in case management. We will accept referrals for case management from any source, including providers, State staff, and community organizations; self-referrals from enrollees and their families; and identification by our strategic partners, including [redacted] To encourage referrals from our community partners, our community health workers (CHW) and peer support specialists will liaise with high-volume physician offices, hospital systems, homeless shelters, and CBOs in their assigned areas to establish themselves as a point of contact for enrollees with frequent ED visits or SDOH needs, and also to assist in identifying hard-to-reach enrollees.

As an example, [redacted] We also maintain and distribute a list of screening triggers for Humana associates to use as a guide to identify and refer enrollees for case management.

HNA Process
We will review HNA data to identify enrollees who qualify as enrollees with SHCN and enrollees who are pregnant. In compliance with Section 2.7.4 of the Model Contract, Humana will offer case management to all identified enrollees with SHCN, regardless of information collected through the comprehensive assessment, HNA, or predictive modeling. In addition, we will offer all pregnant enrollees maternity care management through our MomsFirst program (described further in 2.10.5.1.3 of the RFP).

Other Avenues for Identification
In addition to the methods described above, Humana will apply many other methods to ensure that we identify all enrollees who may benefit from case management. These include:

- Enrollment files: We review enrollment data to identify enrollees with SHCN and enrollees who are pregnant.
- Post-discharge outreach: We will target all enrollees discharging from an inpatient or residential facility for transitional case management. Through the development of the transition plan of care, our CMs will identify enrollees with rising or changing risk who may newly benefit from case management.
- Re-enrollments: Occasionally, an enrollee may be dis-enrolled from Humana for a short period of time as a result of enrollee choice, a temporary change in their eligibility, or an unintentional lapse in re-enrollment. If the enrollee previously engaged in case management re-joins Humana within 90 days following disenrollment, they will be automatically identified for engagement in case management without additional screening. To mitigate unintentional dis-enrollments because of a lapse in coverage, our CMs receive an alert via CGX to reach out and offer needed assistance, including support with re-enrollment, when an assigned enrollee has been dis-enrolled.
- Nurse Advice Line (NAL) and BH Crisis Line notifications: Each enrollee who has contacted the NAL or BH Crisis Line will receive a follow-up call on the next business day to offer assistance and evaluate the enrollee's ongoing needs, including the potential to benefit from case management and/or SDOH support.

2.10.5.1.3 How the Proposer will engage enrollees who may potentially benefit from case management in the program;

We will leverage our relationships with community organizations, providers, and our strategic partners to locate, educate, and engage enrollees who may benefit from case management. In keeping with our commitment to continuous process improvement, we will regularly review our engagement processes to identify successes and areas for change.

Upon initial identification of an enrollee who may benefit from case management, we place an outbound call to educate the enrollee about the program and invite them to participate. We perform a minimum of 5 telephone attempts for each identified enrollee, in addition to mailing a postcard requesting a callback. However, our engagement efforts extend far beyond telephone calls and mailings, as we recognize that these efforts do not work for all segments of our enrollee population. Our engagement methods also include:

- In-person outreach from Humana CHWs and peer support specialists: Our CHWs and peer support specialists will conduct research and in-person outreach to locate enrollees identified for case management whom we have been unable to contact after 3 telephone attempts. When possible, we will pair in-person HNA completion attempts, as described above, with case management education and engagement for identified enrollees. Once a CHW/peer support specialist successfully engages an enrollee for case management, they may conduct a three-way call with the assigned CM to facilitate a direct introduction and schedule a time for the comprehensive assessment.
- Community engagement events: A Humana CM or CHW will regularly attend events hosted by Humana's Louisiana Medicaid community engagement team, including Baby Showers for expectant mothers, to educate and engage enrollees eligible for maternity care management.

- Post-discharge outreach: Our transitional case management and discharge planning processes include identification and engagement of enrollees eligible for case management who have been difficult to reach or who have previously declined case management.
- Engagement following inbound calls to the NAL or BH Crisis Line: During contact following a call to the NAL or BH Crisis Line (as described above), our associates will educate and engage eligible enrollees in case management.

[redacted]

All pregnant enrollees will be eligible to join our maternity care management program, MomsFirst. Through MomsFirst, our enrollees will receive RN-led maternity case management services that are tailored to their acuity level. For pregnant enrollees with 1 or more risk factors that are classified as enrollees with SHCN, these services will follow all case management requirements. In addition to the engagement mechanisms described above, we will employ engagement techniques tailored to our pregnant enrollees, including:

- Coordination with OB/GYNs: To successfully engage enrollees with high-risk pregnancies, including those related to substance use disorder (SUD), we will establish relationships with our network OB/GYNs' offices to encourage case management referrals for enrollees with high-risk pregnancy and enable in-person interventions by case management associates. In addition, we will offer our participating providers a monetary incentive for each completed Notification of Pregnancy (NOP) form submitted for a Humana enrollee. Formal provider communication through the NOP form will enable us to more quickly identify and engage pregnant enrollees in our MomsFirst program. [redacted]
- Prenatal and Postpartum Care Smartphone Application: Through Humana's partnership with [redacted]

Once an enrollee has agreed to case management, our goal is to promote continued engagement that supports the enrollee to take increased responsibility for their health and manage their conditions. A key avenue for ensuring ongoing engagement is to deliver a program that enrollees find to be helpful and meaningful. As demonstrated in the Figure 2.10.5.1.3, we have consistently improved satisfaction rates among our enrollees engaged in case management. In addition, engaged enrollees believe that our program is helping them improve their health. Our methods to ensure the continued engagement of enrollees in case management include:

- Including CHWs and peer support specialists in the enrollee's care, with enrollee consent: By linking our enrollees with a CHW or peer support specialist who share their experiences; is intimately familiar with their community and available resources; and has special training in motivational interviewing, health education, and care navigation, we will support our enrollees to be active participants in case management services.

- Early and frequent engagement with the post-incarceration population: Humana CHWs and peer support specialists will play a key role in engaging our post-incarceration population. With the permission of the enrollee, the CHW/peer support specialist will attend pre-release meetings alongside the CM and conduct a face-to-face visit within a week of the enrollee's release. This level of contact will enable the CHW/peer support specialist to build a relationship with the enrollee, support condition self-management, and encourage ongoing, meaningful engagement.
- Utilizing digital platforms: Humana's enrollee portal provides enrollees with immediate access to their care plan including the crisis plan, claims, authorizations, and contact information for Humana. If an enrollee in case management does not have a smartphone or does not have adequate data or minutes to stay engaged in case management (including the ability to contact their CM as needed and use the enrollee portal), our CMs will help them access Humana's added benefits to receive a smartphone and/or unlimited minutes and data.

[redacted]

Innovation Spotlight: Case Management for Pregnant Enrollees with Substance Use Disorder (SUD)

Between 2012 and 2017, the number of neonatal abstinence syndrome (NAS) cases in Louisiana rose by 50 percent. This trend indicates a need to provide additional support and services to pregnant enrollees with SUD to increase the likelihood that they deliver a healthy infant. [redacted] In the remainder of the State, Humana associates will provide a similar level of support to pregnant enrollees with SUD, including the involvement of a Humana peer support specialist. [redacted]

2.10.5.1.4 How the Proposer will identify the appropriate tier of case management for an enrollee using objective measures and criteria, which types of support are provided in each tier, and the process for developing an individual plan of care;

Initial Stratification

Figure 2.10.5.1.4-A illustrates our identification and stratification process. We will assign an initial risk level to each enrollee based on their enrollment file and HNA, taking into account any State contractual requirements for key populations, including enrollees being released from a Department of Corrections (DOC) facility and enrollees who are part of the Department of Justice (DOJ) Agreement Target Population. This initial stratification will help us prioritize our outreach efforts, within the bounds set by the Model Contract and DOC procedures. In addition, we rely on our Medicaid Severity Score predictive model, which runs monthly, to help us identify enrollees with a changing risk level who may newly benefit from case management or who may need to move to a different tier of case management, in accordance with the objective measures and criteria described below.

Comprehensive Case Management Assessment
After the enrollee has agreed to participate in case management, our CM coordinates with the enrollee and their support system to identify a date and time to complete the comprehensive assessment and create the enrollee's care plan. The assessment and care plan will be completed within 30 days for enrollees stratified to Tier 2 and Tier 3, and 90 days for enrollees stratified to Tier 1.

We have designed our comprehensive assessment to adhere to the tenets of person-centered planning and evaluate all factors that may impact an enrollee's health and well-being. Through the assessment process, we aim to gain insight into the enrollee's strengths, goals, preferences, supports, and services in order to create a care plan tailored to their circumstances and needs. Our assessment includes the following components:

- Assessment of the home environment
- Review of SDOH, including housing, food insecurity, physical safety, transportation, education, and employment
- Enrollee goals
- Enrollee's health status, including condition-specific issues
- BH status, including screening for clinical depression (using the Patient Health Questionnaire-2), SUD, problem gaming, and tobacco usage
- Clinical history, including medications
- History of adverse childhood experiences that may impact health
- Current services, including durable medical equipment (DME) and treatment plans
- Evaluation of caregiver resources, including adequacy, involvement, and level of decision-making
- Cultural and linguistic preferences
- Life planning activities, covering advance directives, legal assistance, financial planning, and family planning

- Hearing and visual preferences or limitations
- Service delivery preferences

For enrollees with primary BH needs, a licensed mental health professional (LMHP) CM will administer additional questions from the following assessments:

- Healthy Days
- Mini-Mental Status Exam
- Brief Psychiatric Rating Scale
- UCLA Loneliness Scale

In addition to the questions above, we will administer a maternity-specific assessment to pregnant enrollees identified as high-risk. Topics include:

- Pregnancy history
- Psychological growth and developmental assessment
- Family planning and birth spacing education
- Needed referrals to community partners and state agencies, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), EarlySteps, and Nurse-Family Partnership

Objective Measures, Criteria, and Support Provided for Each Case Management Tier

We will use assessment results, in conjunction with the CM's clinical judgment, to refine the enrollee's stratification level in accordance with the objective measures and criteria, described in Table 2.10.5.1.4-C below. In compliance with Sections 2.7.7 and 2.7.8 of the Model Contract, enrollees of the DOJ Agreement Target Population will be assigned to Tier 2 or Tier 3.

Core Supports

We will provide a core set of supports for all of enrollees in case management, in addition to tier-specific services described in Table 2.10.5.1.4-C, below. Core supports include:

- Care coordination
- Assistance in navigating the health care system
- Education on available benefits, including VAB
- Disease-specific education and self-management support, including linkage with educational materials provided through [redacted], and referrals to classes conducted by our Louisiana Medicaid community engagement team at Humana neighborhood locations and other community centers
- Support from a CHW or peer support specialist, as indicated and with enrollee consent
- Referrals to resources to address SDOH, including [redacted]

Table 2.10.5.1.4-C reflects the contractually-required level of support provided for each tier. Our CMs may increase the frequency of contact and/or change the method of contact to meet the enrollee's acuity level and/or enrollee preference. Per section 2.7.6 of the Model Contract, as amended, we may reduce or substitute the frequency and/or method of contact upon request of the enrollee or enrollee's representative.

Table 2.10.5.1.4-C – Objective Measures, Criteria, and Support Provided for Each Case Management Tier		
Tier 3: High Risk		
Overall Goals: Preventing institutionalization and adverse outcomes; meeting care goals, including self-management and SDOH needs; reducing barriers to care; reducing disease burden	Objective Measures: Enrollees who have had 2 or more unplanned inpatient admissions or inappropriate ED visits within the past 6 months	Criteria: Enrollees who have physical health, BH, or SDOH needs that place them at imminent risk for a readmission, unnecessary ED visit, or institutionalization
Support Provided: • Intensive case management to support clinical care and SDOH needs, including face-to-face support from a CM and CHW/peer support specialist assistance as needed • Completion of an in-person comprehensive assessment and creation of an individualized care plan within 30 days of identification of CM need, inclusive of the enrollee's physical health, BH, and/or SDOH needs • In-person MDT meetings at least monthly (or as required in their care plan) in enrollee's preferred setting • Quarterly in-person reassessment (at a minimum) or upon change in enrollee condition or request of enrollee, enrollee's authorized representative, or member of the MDT • Monthly updates to the care plan, accompanied by attestation to PCP and enrollee		
Tier 2: Medium Risk		
Overall Goals: Preventing institutionalization and adverse outcomes; meeting care goals, including self-management and SDOH needs; reducing barriers to care; reducing disease burden; promoting optimal health status	Objective Measures: Enrollees who have had an unplanned inpatient admission or inappropriate ED visit within the past 6 months	Criteria: Enrollees who have physical health, BH, or SDOH needs that place them at risk for a readmission, inappropriate ED visit, or institutionalization
Support Provided: • Completion of an in-person comprehensive assessment and creation of an individualized care plan within 30 days of identification of CM need, inclusive of the enrollee's physical health, BH, and SDOH needs • Monthly MDT meetings • Monthly case management meetings, led by a CM with CHW/peer support specialist assistance • Care plan updates and in-person reassessments each quarter (at a minimum), or upon change in enrollee condition or request of enrollee, enrollee's authorized representative, or member of the MDT • Quarterly care plan attestation to PCP and enrollee		
Tier 1: Low Risk		
Overall Goals: Preventing adverse outcomes, improving self-management of condition, meeting care goals, promoting optimal health status, reducing barriers to care	Objective Measures: Enrollees who have not had an unplanned inpatient admission or unnecessary ED visit within the past 6 months	Criteria: Enrollees with complex and/or co-occurring physical and behavioral conditions and/or SDOH needs that are well-controlled
Support Provided: • In-person comprehensive assessment/care plan within 90 days of identification of case management need, inclusive of the enrollee's physical health, BH, and SDOH needs • Quarterly case management meetings (or as required by care plan), led by a CM with CHW/peer support specialist assistance • Annual in-person care plan and reassessment (at a minimum), or upon change in enrollee condition or request of enrollee, enrollee's authorized representative, or member of the MDT • Attestations of annual updates to care plan communicated to PCP and enrollee		

Table 2.10.5.1.4-C – Objective Measures, Criteria, and Support Provided for Each Case Management Tier

Transitional Case Management	Overall Goals: Preventing adverse outcomes, including readmissions; improving self-management of condition; promoting regular engagement with providers in an outpatient setting	Objective Measures and Criteria: Individuals transitioning between institutional and community care settings, including but not limited to: transitions to/from inpatient hospitals, nursing facilities, psychiatric facilities, psychiatric residential treatment facilities, therapeutic group homes, permanent supportive housing, intermediate care facilities, residential SUD settings, and transitions out of incarceration
	Support Provided: • Development of a transition plan of care • Coordination to ensure aftercare services are in place 30 calendar days prior to discharge for enrollees preparing for discharge from a psychiatric residential treatment facility, therapeutic group home, or intermediate care facility • Facilitation of communication between the discharging facility and enrollee's PCP and BH providers regarding treatment received and contact information • Follow up within 72 hours following discharge/transition, with additional follow up as detailed in discharge plan; follow-up may be face-to-face in accordance with the enrollee's transition plan of care • Coordination across MDT involved in transition case management • Support from housing specialist for enrollees identified as homeless at time of care transition • Screening for Coordinated System of Care (CSoC) for youth in an out-of-home placement or at risk of an out-of-home placement	

Process for developing an individual care plan

Our care plan development process is person-centered and enrollee-driven, with the support of the enrollee's representative and other members of their chosen support system. Using the assessment as its base, the care plan focuses on those services and supports that can help the enrollee achieve their short- and long-term goals, strengthen self-determination, and move the enrollee along the path to improved health. The care plan is fully comprehensive, including the enrollee's physical health, BH, and SDOH services and needs. Our CMs complete the care plan in real time, in conjunction with the enrollee and their support system, using CGX. Upon completion, the enrollee and their representative can access the care plan via the enrollee portal, with a printed copy provided upon request, while the enrollee's providers (including their PCP and BH provider) can access the enrollee's care plan via our provider portal, Availity. We will complete attestations of monthly, quarterly, or annual updates to the care plan (as dictated by the enrollee's case management tier) and communication of the care plan to the enrollee and the enrollee's PCP. During subsequent case management meetings, we will discuss the enrollee's progress toward their goals, identifying any needed services. We will update care plans in compliance with the schedule outlined in Section 2.7.10 of the Model Contract, including when the enrollee's circumstances or needs change significantly; upon request of the enrollee, their parent, or legal guardian; or upon request of a member of the MDT.

Facilitating engagement in care plan development

The enrollee will be at the center of our Louisiana Medicaid Model of Care, and our process emphasizes their involvement at every step, including each case management and MDT meeting and the assessment and care planning process.

Recognizing the varied linguistic needs of Louisiana Medicaid enrollees, including non-English speaking and non-verbal enrollees, we recognize that we may need to take extra measures that account for their spoken languages and communication abilities. Our CMs have access to a variety of tools and resources to facilitate the assessment and care planning process. Enrollees who are non-English speaking are assigned to a CM who speaks their preferred language, when possible. If this is not possible, our CMs will ensure that an interpreter participates in all

interactions. For enrollees who are visually or hearing impaired, we will use Telephone Typewriter (TTY), braille, and other interventions to facilitate their full engagement in the case management process. In addition, Humana regularly translates care plans into other languages upon request. Our Concierge Service for Accessibility is available to help enrollees and CMs arrange these services.

Managing Complex Needs: An Enrollee Story

Fred, a Humana Florida Medicaid enrollee, was referred to our CCS team by a homeless shelter in Miami. Fred had been admitted to the hospital at least once a month for the past several months due to non-adherence to his medications for physical health and BH conditions. However, Humana's previous efforts to engage him in case management had been unsuccessful. A Humana CM, Gretchen, leveraged the shelter's referral to reach Fred and help him move into an assisted living facility (ALF) that could better meet his needs. However, Fred expressed resistance to any move to a facility; within a week of a placement in an ALF or shelter, Fred would move back into a warehouse where he had lived previously. Fred's blood pressure became poorly controlled, as he was non-adherent with his medication regimen. His BH symptoms also worsened, and he became suicidal. At this time, Fred was involuntarily admitted to an inpatient psychiatric unit.

Throughout these events, Gretchen continued to contact Fred to encourage him to move out of the warehouse and to engage in care. After several months, Gretchen was able to convince Fred to begin seeing a BH provider. It took several tries, but Gretchen finally found a BH provider whom Fred agreed to see on an ongoing basis. With the support of his provider and Gretchen, Fred began taking his medications as prescribed. Recognizing Fred's resistance to moving into a facility, Gretchen also worked with him and Humana's housing specialist to identify a living option that would meet his needs and preferences. **After reviewing several options, Fred stated that he wanted to look for a room to rent. Our housing specialist reviewed more than 100 ads for rooms, and after 3 weeks, Fred found a small apartment that he liked.** The apartment provided both privacy and easy access to transportation. Gretchen also linked Fred with community resources to build his social network and address his SDOH needs. Since Fred has moved into his apartment, he has continued to engage with his providers and has stabilized his health. He has not had any further hospitalizations.

MDT Engagement

During MDT meetings, the enrollee's lead CM (who may be their Humana CM or a CM from their PCP or BH provider's office) gathers feedback on the enrollee's care plan from their support system, providers, CMs from State agencies and other plans, and other individuals identified by the enrollee. This feedback is incorporated into the enrollee's care plan, along with their treatment plan for specialized BH services (with enrollee consent).

Reflecting our commitment to person-centered, holistic case management, Humana is committed to coordinating with third-party resources who serve our enrollees. Humana CMs will invite third-party CMs to join our enrollee's MDT, as appropriate and upon enrollee request. For example, in Florida where prescribed pediatric extended care (PPEC) is a carved-out service, Humana CMs invite PPEC providers and CMs to attend MDT meetings for PPEC-engaged enrollees. Additionally, we will participate in any MDTs organized by third parties (as requested) to gain a full understanding of our enrollee's needs and contribute our knowledge of the enrollee's services received under Humana.

2.10.5.1.5 How the Proposer will coordinate with providers and state staff that may provide case management support to enrollees so as to not duplicate services.

Our engagement with Louisiana providers and our experience coordinating case management services with providers and state staff through our Medicaid operations in other states informs our approach to coordinating with providers and State staff that may provide case management support. We have established relationships with 10,600 providers in Louisiana across our lines of business, supported by [redacted] Humana associates and 14 local Humana offices. Through our meetings with more than 50 Louisiana Medicaid provider organizations to date (including health systems, Human Services Districts, federally qualified health centers (FQHCs), and private providers), we have gathered the following feedback about what Louisiana providers look for in a successful case management partnership with a Medicaid MCO and incorporated it into our processes, as described in Table 2.10.5.1.5-D below:

Table 2.10.5.1.5-D – Incorporation of Louisiana Medicaid Provider Feedback into Humana's Case Management Program	
Louisiana Medicaid Provider Feedback	**How Humana's Case Management Program Incorporates their Feedback**
Providers desire greater access to enrollee data to assist in care coordination, including ongoing access to claims data and ADT feeds.	Through our provider portal, Availity, all network providers can see claims data, assessment results, care plan, and admission and discharge information for the Humana enrollees for whom they care.
MDTs serve an important care coordination function, particularly for enrollees with complex and/or co-occurring BH and physical health needs.	With the enrollee's permission, we will invite all treating providers to the enrollee's MDT. This will facilitate communication between providers and support the creation and implementation of a comprehensive, integrated care plan.
To better support follow-up care and chronic condition management, providers need to be engaged in post-discharge planning. More immediate notification of hospitalizations and ED visits is essential to this process.	We will auto-fax admission and discharge information to providers for enrollees in case management (if a fax number is on file). If the enrollee is in case management at the time of admission, their Humana CM is involved in discharge planning and will facilitate communication between discharging and community providers, including scheduling follow-up visits.
Enrollees with SPMI (in particular) have often already formed strong relationships with their care teams at a provider level. It is important that plan-led case management efforts support, rather than disrupt, these relationships.	If an enrollee is receiving case management from a provider, we will support that provider's CM to serve as the lead CM on the MDT. In addition, we will aim to coordinate and/or combine Humana MDT meetings with those hosted by the provider to reduce duplication and support provider-enrollee relationships.

Our Medicaid experience has also provided insights into best practices in coordination with provider-led case management. Nearly half of our Florida Medicaid enrollees and one-quarter of our Louisiana Medicare and commercial enrollees are served by a provider who has a sub-capitation arrangement with Humana. As these arrangements give our providers full responsibility for the care of our enrollees, many have chosen to employ care coordinators and other support personnel to close care gaps, link enrollees with specialists, and respond to SDOH needs. As a result, we have developed specialized processes that accommodate provider-led case management and reduce duplication with our own case management program. We have summarized an example of such an arrangement below.

Coordination with Provider-Led Case Management: A Case Study from Humana Florida Medicaid

In 2016 through enrollee feedback, Humana recognized the need to have a more streamlined approach for connecting with enrollees after discharge from a hospital inpatient admission. We began polling our PCPs to determine which offices were conducting outreach to their enrollees post-discharge and the types of services offered. We identified Doctors Medical Center (DMC), a patient-centered medical home (PCMH) that serves [redacted] Humana Medicaid enrollees and offers transportation, social work, and case management services, as a partner for our collaborative, streamlined initiative. DMC was conducting outreach to its enrollees post-discharge to set up timely follow-up PCP appointments, arranging transportation when needed, making referrals to specialists, ensuring home health services had been scheduled and DME had been delivered, and offering short-term case management. Our case management team worked with DMC to develop a process that would align the efforts of both organizations and end duplicative outreach by various departments, a frustration identified by our enrollees. We jointly decided DMC would conduct outreach to their enrollees following inpatient or observation utilization, rather than Humana, and would refer to Humana for additional needs, including disease management. We implemented the revised process in 2016, which has worked well for our enrollees, our providers, and Humana. **DMC reported that they rarely receive negative feedback from enrollees regarding follow-up calls from multiple sources after discharge since implementing this initiative, and we achieved a** [redacted]

Our Process for Coordinating Case Management with Providers

We will establish a set of standardized work processes designed to coordinate with provider-led case management and reduce duplication, as illustrated by the DMC case study above. These processes include:

1. Identifying providers and State staff offering case management services: As part of their routine communications with our Medicaid providers, Humana Provider Relations (PR) representatives will determine provider capabilities in the area of case management, including the provider's employment of CHWs, peer support specialists, care coordinators, or social workers; discuss specific case management services offered by providers; and identify a point of contact with the provider for all case management queries.
2. Establishing a communication process for case management inquiries: Humana will provide a dedicated phone line and e-mail inbox for all case management inquiries. We staff the phone line during business hours, with call-backs provided within 1 business day for any messages left after hours. Our PR representatives, Provider Handbook, and website share the details of the phone line and e-mail inbox for our providers.
3. Identify enrollees receiving case management from a provider: As a routine part of our case management process, our CMs will contact the PCP and/or BH provider of assigned enrollees to introduce themselves, educate them on the case management program, and invite them to join the enrollee's MDT (as applicable). In addition, our CM will ascertain if the PCP and BH provider are providing case management services. If so, we note these services and point of contact on the enrollee's care plan to enable ongoing coordination.
4. Coordination of assessments and care planning: While Humana will retain responsibility for completion of the comprehensive assessment and care plan, we will incorporate any provider-created care and treatment plans into the enrollee's Humana care plan, with enrollee permission, and will incorporate provider feedback on the care plan through the MDT (as described above). Our CMs will secure the provider attestation as required.
5. MDT meetings: If an enrollee is receiving case management from their PCP or BH provider, we will support the provider as the lead CM on the MDT. During these meetings, we will review the enrollee's care plan and progress toward meeting goals, invite the provider of case management services to discuss how they are supporting the enrollee, and discuss additional avenues for coordination and collaboration. Humana CMs will also join team meetings to which they are invited by the provider. Whenever possible, our CMs will aim to coordinate Humana MDT meetings with those hosted by the provider, including exploring options to combine team meetings (as long as contractual requirements can be upheld).
6. Post-discharge planning: Our UM coordinator will work closely with all providers, including the enrollee's PCP and BH provider, to coordinate discharge planning for any enrollee admitted to an inpatient or residential facility, regardless of their prior enrollment in case management. In addition to faxing admission and discharge information to providers serving enrollees in case management (as described above), we will work with our Louisiana Medicaid network providers to gain their support for placing Humana UM nurses in high-volume inpatient facilities. [redacted] and through our Medicaid plans in other states. In addition, our CHWs will build relationships with large provider practices in their assigned areas to support referrals to Humana programs, community resources, and facilitate communication between the provider practice and Humana for case management and discharge planning needs. We will also place Humana CHWs in select hospitals to assist in discharge planning, including linkage with community resources to address enrollee SDOH needs and to promote communication with the enrollee's PCP or BH provider.

Our provider portal, Availity, offers our providers in-depth information about the enrollees for whom they care. This includes enrollee care plans, assessments, claims, diagnoses, admissions, lab results, and information about the enrollee's other coverage.

We will continue to evolve our process for coordination with provider-led case management, including supporting providers to offer more case management services. This works hand in hand with our value-based purchasing approach, which aims to move providers into full value arrangements over the life of the Contract. In the box below, we detail our unique planned partnership with [redacted]. As we evaluate and refine

this program, we will assess its applicability to other FQHCs and providers interested in partnering with us for case management services.

Advancing Coordination with Provider-Led Case Management: Our Partnership with [redacted]

[redacted]

Our Process for Coordinating Case Management with State Staff

Humana will work with each agency providing case management to our enrollees to develop case management coordination procedures that are amenable to both parties. The assigned Humana liaison will take charge of developing these procedures, in coordination with the case management team. Each agency will be provided with a direct number to reach the CCS team, as well as a shared e-mail inbox to transmit information and send queries.

Upon identifying an enrollee receiving case management from the State, the Humana CM will reach out to the agency to identify the responsible CM (if given permission by the enrollee), introduce themselves, and discuss next steps, including the next MDT meeting. We will invite State CMs to join the enrollee's MDT and share the care plan upon request. When the enrollee has a State-developed care plan, we will incorporate that information into the enrollee's Humana care plan (with the enrollee's permission). As with our network providers, we will engage State CMs in our discharge planning process to support the coordination of services, including follow-up appointments, and to reduce the number of contact points for our enrollees.