2.10.10 Utilization Management

2.10.10.1 The Proposer should describe how it will satisfy the requirements for authorization of services set forth in the Contract. The Proposer should submit a flow chart depicting the proposed workflow.

Humana has established policies and procedures in place to meet the requirements set forth for authorization of services in Section 2.12.6 of the Model Contract. The overarching goal of Humana's Utilization Management (UM) program is to ensure our enrollees receive the right care, at the right place, and 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.

Prior Authorization List (PAL) and Review Processes
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 prior authorization 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
- Chief Medical Officer (CMO)
- Behavioral Health Medical Director (BH MD)
- Provider Network
- Clinical Strategies
- Clinical Intake Team (CIT)
- Complaints and Appeals
- Provider Communications (including feedback from our Louisiana Provider Advisory Council)
- Claims

Reducing Administrative Burden on Providers: Humana's Gold Card Program
Humana is waiving prior authorization requirements for those providers who have consistently exceeded prior authorization performance and quality criteria. These high-performing providers will have the ability to ability to bypass the standard outpatient prior authorization process for specialty care, surgical procedures, and high-tech imaging (e.g., MRI, SPECT).

Service Authorization Process
We have included the flow chart depicting our authorization processes in **Figure 2.10.10-A.**

The enrollee, their primary care provider (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 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
- Facsimile
- Telephonically, including Interactive voice response (IVR)

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 the state of Louisiana.

Our Louisiana-based Chief Medical Officer (CMO), Behavioral Health Medical Director (BHMD), and Medicaid UM Manager will have direct involvement with (and oversight of) UM for our Louisiana Medicaid program. The **Louisiana-based CIT** will be the primary point of entry for telephonic and manual authorizations and referral requests for Louisiana Medicaid. The team is supported by a single phone system, operating policies, procedures, and workflows.

The CIT provides non-clinical staffing for the intake of authorization requests made via electric submission via Availty.com, phone and fax, and makes requests for supporting clinical information, if necessary.

Cases requiring clinical review will be referred to Humana Louisiana Medicaid prior authorization associates for processing. The prior authorization associates process the request (reviewing the clinical criteria) and refer to our Louisiana Medicaid Medical Director if they are unable to approve based on the clinical criteria.

Our UM associates, under the supervision of appropriately licensed health professionals, receive and perform data entry of requests from providers for inpatient or outpatient services. We forward requests for services that require clinical review to a clinical associate based on the submitted documentation and clinical guidelines. A clinical supervisor is available to non-clinical associates to provide guidance and support their activities.

Under appropriate supervision by a registered nurse (RN) or licensed mental health professional (LMHP), experienced medical professionals with an active and valid Louisiana license (e.g., licensed practical nurses) use approved clinical decision support tools to review requests against plan benefits and established criteria. They approve services that meet criteria or clinical care 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 clinical practice guidelines.

Authorization System Capabilities
Humana's clinical platform CareHub has been configured to support authorization determination efficiency, promote accuracy in service determination decisions, and reduce the administrative burden on our providers. Our clinical workflow system, Clinical Guidance eXchange (CGX), supports an integrated approach to UM, processing both physical and behavioral health (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 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 Customer Care system, to enhance user efficiency
- UM letters, such as "Notice of Action," integrated within system
- Automated business rules integrate with prior authorization list to automatically approve, as appropriate, or pend in "real time" to appropriate clinical team for review
- Integration of our clinical platform for UM and case management – including physical health, BH, and social determinants of health (SDOH)

Mechanisms to Ensure Consistent Application of Review Criteria
Consistent application of UM 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 these reviewers using methods endorsed by the National Committee for Quality Assurance (NCQA). ██ f they score less than the threshold, they will 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 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 perform IRR audits of physician and non-physician reviewers at least annually to measure their consistency in applying criteria in UM decision-making.
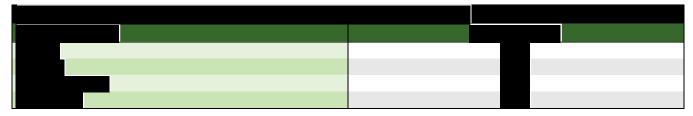
- Monthly audits: We conduct monthly audits on UM associates making medical necessity determinations to ensure consistency in decision making. We review one percent of each UM professional's determinations each month to ensure criteria application consistency.
- Grand rounds: Humana understands the value of creating a forum where clinical associates can come together to discuss consistency in clinical decision-making. As such, 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 doctors choose the cases. The discussions foster clinical learning and development, consistent decision-making, trend identification, and sharing of quality improvement 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 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.

Service Authorization Timeliness

We believe that UM processes and service determinations should take place in a timely, efficient manner and should have a minimum 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**.
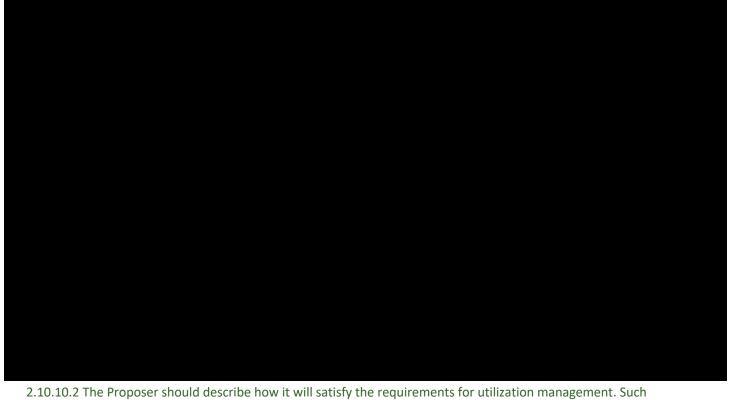
We are successful in meeting contractually required timeframes associated with standard, expedited, concurrent/urgent, and retrospective reviews. Table 2.10.10.1-A below includes our compliance with service authorization timeframes in our Florida Medicaid Program.

We have the experience and existing processes in place to meet all service authorization time frame requirements listed in Section 2.12.9 of the Model Contract. Our detailed processes for authorization determinations will be outlined in our Louisiana UM Program Description and associated policies and procedures.

Humana's flow chart depicting our proposed workflow (from initial request to final disposition, including the proposed workflow for expedited authorizations) is shown below.

2.10.10.2 The Proposer should describe how it will satisfy the requirements for utilization management. Such description should include:

Overview of Humana's UM approach
Humana has established processes and procedures (P&Ps) in place that meet Contract requirements listed in Section 2.12 of the Model Contract. We employ a dynamic UM program to provide comprehensive delivery of healthcare services and ensure our enrollees continuously receive the appropriate level of care based on medical necessity. We have built our UM program upon decades of lessons learned serving high-need populations on a large scale, and continually enhance the program based on our experiences. Humana integrates physical, BH, and pharmaceutical management in all phases of the program, and also recognizes the critical impact of social factors. Our processes encompass activities associated with review and authorization of medical services, mental health and substance abuse healthcare services, appropriate resource utilization, and discharge planning. We strive to coordinate and cooperate with providers in the Humana delivery system by providing a comprehensive approach that meets the medical needs of our enrollees, from episodic management to the routine coordination of care, to acute and post-acute care, as well as preventive care, and case management.

2.10.10.2.1 The proposed criteria to use in its utilization management process and how such criteria will be applied, including both determination of appropriateness of treatment and site of treatment;

UM Clinical Criteria and Review Processes
When reviewing requests, we apply all contractual, state, and federal guidelines, including CMS transmittals and Medicaid Contractor Bulletins. We maintain a corporate license to use MCG Care Guidelines, externally developed, peer-reviewed, evidence-based, standardized criteria created to support effective UM. Health plans 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 & 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.

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 Member Handbook and Benefit Grid
3. Humana Medical Coverage Policies
4. MCG
5. Early and Periodic Screening and Diagnostic Treatment (EPSDT) Guidelines (as applicable)

When necessary, we supplement MCG with clinically sound and reputable clinical practice guidelines (CPGs) from organizations such as:

- American Academy of Child and Adolescent Psychiatry
- American Society of Addiction Medicine
- 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)
- American Congress 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)

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

The purpose of the UM process is to evaluate and determine coverage for (and appropriateness of) medical care services, as well as to provide needed assistance to practitioners or enrollees (in cooperation with other parties) to facilitate appropriate use of resources and appropriate settings of care for the enrollee's condition. We understand there cannot be a one-size-fits-all approach to determining the appropriate services for all our enrollees. Humana provides guidance to enrollees and facilitates coordination of care as enrollees navigate through the healthcare delivery system.

Utilization Management and Improving our Enrollees' Health: NICU Program
Humana's neonatal intensive care unit (NICU) program exemplifies how we improve our enrollee's health through the intersection of utilization management and case management. Our NICU team and the assigned Case Manager (CM) are notified upon baby's admission to the NICU, and there is an ongoing clinical review through the inpatient stay for: – medical necessity – care coordination – interventions – discharge planning The NICU nurse and the CM participate in weekly rounds with the Medicaid Medical Director. Post-discharge from the hospital, a Humana Community Health Worker (CHW) ██████████████████████████ ██ ██ We work across all areas of the health team such as social workers, discharge planners, nurses, doctors, and the home health agency to ensure the baby is getting the very best treatment and once home, continuing to get the best care. If the infant is readmitted within the first 30 days, the NICU team manages the readmission. The CM continues to outreach to the enrollee and the family up to the infant's first birthday (based on continuing Humana eligibility).

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 Louisiana 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 Humana's Chief Medical Officer (CMO)/BH Medical Director (BH MD) 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.

Collecting, Monitoring, and Analyzing Utilization Data and Patterns
Our UM program uses innovative data analytics systems to monitor enrollee utilization and ensure that enrollees receive the right care, at the right place, at the right time. We proactively monitor utilization trends to assess population health of our enrollees and to identify gaps in care and areas for quality improvement. Our UM program also incorporates numerous measures to monitor and evaluate progress toward meeting goals. We collect, analyze, trend, and monitor data on a systematic basis to facilitate corporate quality improvement and to address any identified barriers. Data collected through Humana's UM program allows us to more effectively:

- Promote appropriate utilization
- Monitor for inappropriate utilization
- Educate our enrollees and providers
- Identify and refer suspected cases of fraud, waste, and abuse (FWA)

Utilization Management Committee
The Louisiana Utilization Management committee (UMC) is responsible for review of utilization data and related statistics, analysis of trends, and recommendation for improvement strategies. The UMC will meet at least quarterly and will be co-chaired by the CMO and the BH MD to promote integration of physical health and BH. Participants will include:

- Humana Chief Medical Officer
- Humana Behavioral Health Medical Director
- Utilization Management representative
- Quality Operations Compliance and Accreditation representative

2.10.10.2.2 The Proposer's process for monitoring and addressing high emergency room utilization;

Identifying High Emergency Room Utilization

Humana's processes for monitoring high emergency department (ED) utilization feature robust IT infrastructure and reporting capabilities utilized alongside our enrollee-centered case 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. ███ ███. It enables Humana to identify and target high-risk enrollees for clinical interventions that reduce avoidable ED visits, which creates the following benefits:

- Opportunity 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-physician care partnership

Our **High-Utilizer Report** (HUR) monitors and tracks ED utilization at the enrollee level, identifying those enrollees who have disproportionately high ED utilization and are what we consider "ED frequent fliers." We utilize this report to identify high-risk enrollees needing case management outreach to address outstanding medical, behavioral, or SDOH needs ████████████████████████████ ███████████████████████████████████████ ███████████████████████████████████████

Humana is currently connected to Ochsner via EPIC, which provides us real-time clinical data that we leverage to enhance care. We have direct connections built with almost all of the leading electronic health record software systems including, Allscripts, eClinicalWorks, Athena Health as well as multiple state HIEs.

Finally, key utilization indicators are included in Humana's sophisticated **Early Indicator Reporting (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 are able to see overall performance at a glance and can 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.

Early Indicator Report in Action: South Florida ED Utilization
Every month, Humana's Florida Medicaid Health Services teams meet to review the EIR, discuss emerging trends, year-over-year metric comparisons, additional reporting needs, and initiatives/pilots designed improve metrics.
The metrics and discussions help focus our efforts on areas of opportunity, such as evaluating network adequacy of our PCPs and urgent care centers (UCC). When Monroe County's ED visits per thousand radically increased, Health Services requested a PCP and urgent care geomap to ensure our enrollees had access to care. █████████ ██ Health Services then worked with contracting to identify UCC contract opportunities in order to expand access to care and alternatives to ED.

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 Parishes, we utilize our enrollee-centric clinical and case 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 through the tools above, we try to engage that enrollee in case management. **Case 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 which conditions they should visit primary care, urgent care and the ED for).

███ CMs will be trained to educate enrollees and caregivers on how to contact our Nurse Advice Line (NAL) in the event of a non-life-threatening situation. ████ ██ ████ removing the need for a preventable ED visit and delivering high-quality, appropriate care.

Through our **provider engagement model and our connectivity to HIE ADT data**, we are able deliver daily ED reports to our network PCPs, notifying them that one of their Humana enrollees visited the ED. This information allows our PCPs to 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 to develop strategies to reduce potentially preventable ED visits. We will conduct quarterly meetings with our Louisiana providers to review data specific to their group, including:

- ED utilization based on the day of the week (weekday versus weekend)
- 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 **Network Development** team to assist in examining network adequacy in areas with high ED usage. We review access to primary care and urgent care centers, as well opportunities to promote and incentivize after-hours and weekend hours with our PCPs.

2.10.10.2.3 The Proposer's process for pre-admission screening and concurrent reviews;

Preadmission Screening

███ to ensure our Louisiana 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 team reaches 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 available community resources
- Identify and authorize any post-discharge services such as home health or rehabilitation
- Schedule transportation if necessary

Concurrent Review

We perform front-end reviews upon notification of an admission, and concurrent reviews on any extension of previously approved, ongoing course of treatment (over a period of time or number of treatments). Humana always considers requests for ongoing inpatient care as urgent. We have nurses and physicians on call to conduct concurrent reviews for ongoing services. Our Concurrent Review (CR) associates play an important role in discharge planning with facility staff. Their role is to assure timely discharge, with a safe discharge plan in place, including a crisis plan (addressing housing instability, food insecurity, personal safety, etc.) as applicable for the enrollee's situation**.**

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

- Personalized enrollee experiences with face-to-face engagement to assess individual enrollee needs with a holistic approach.
- Individualized assessments to identify gaps in care and SDOH needs.

- Real time enrollee intervention and coordination of services. Onsite nurse can proactively anticipate and plan enrollees' needs and coordinate services to ensure a successful transition of care from the inpatient setting.
- Collaborative approach of care and enrollee engagement involving the onsite nurse liaison, PCP, hospitalist, Humana Case Management team and hospital team.
- Improved provider relationships and engagement amongst interdisciplinary teams to meet individual member needs.

Humana's On-site Nurse Liaisons: Provider Support
"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 CHWs to facilitate a smooth discharge and transition back into the community. Our concurrent review and discharge planning processes and include:

- Psychosocial assessment of enrollees to identify gaps in care, educational needs related to disease processes, medication adherence, and SDOH needs
- Communication of enrollee's needs to PCPs to better assist with discharge decisions and coordination of care
- 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, and acute rehab levels of care
- Referral for case management, DM, and social services based on enrollees identified needs. Communicate and provide updates to interdisciplinary team for transition of care to the outpatient setting
- Coordination and communication with the hospital team and outpatient providers on enrollees' plan of care
- Enrollee and family education on disease processes and available services

As a part of our ongoing concurrent reviews, Humana holds UM rounds for their enrollees in case management in which the 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 and make referrals to the appropriate resources, establish prior authorizations that may be needed prior to discharge.

Enrollee Story: Humana Concurrent Review in Action
In November 2016, 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 CR 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 CR nurse **worked with the hospital nurse manager** to ensure the staff trained the family on suctioning/bolus feeding and the general day-to-day care. The Humana social worker and CR nurse collaborated with the home care vendor daily to ensure supplies were being delivered in preparation for discharge. The CR nurse also **worked closely with our respiratory supply vendor** to provide a vent, suction, and back up vent with extended battery life.
The CR nurse **provided periodic updates to the PCP** and secured specialized on-site CM for tele-health (remote monitoring of ventilated enrollees 24 hours a day, seven days a week). The **CR nurse acted as the centralized contact** in the coordination of services, 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 CR nurse's efforts, this complex enrollee successfully stayed home without a readmission for over six months.

2.10.10.2.4 How the Proposer complies with mental health parity requirements; and

Humana is committed to ensuring Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requirements are embedded throughout all Humana operations. We utilize MCG guidelines for both medical and behavioral determinations, providing a basis for consistent decision-making. We receive notification when a new policy or

change in policy is implemented at the state, national or contract level. Within the Clinical (Medical/Surgical) and Mental Health/Substance Use Disorder (MH/SUD) Utilization Management space, Humana has processes, controls, and governance structures in place for applicable non-quantitative treatment limitations. These include but are not limited to: prior or ongoing authorization requirements, benefit classification, utilization review processes, medical necessity standards, and experimental/investigational definitions.

2.10.10.2.5 How the Proposer identifies and mitigates over-utilization, including any targeted categories.

Monitoring overutilization is a core capability of Humana's UM program. We draw upon our comprehensive and innovative data analytics systems to monitor enrollee utilization and ensure that enrollees receive the right care, at the right place, at the right time.

Identifying Over-utilization

Humana has established a robust, logic-driven process to monitor, identify, and respond to patterns of overutilization. Our best-in-class data systems provide a platform to proactively monitor for overutilization of certain services and identify any outliers in the data that may indicate a utilization or quality of care issue. This process identifies potential inconsistencies in service utilization by comparing the approved services and the enrollee's needs documented in the plan, with utilization parameters. Data is analyzed for medical, BH, and pharmacy utilization. Frequency of selected procedures, ED visits, and inpatient measures from HEDIS are reviewed as relevant monitors for over- and under-utilization management trends. Utilization indicators are selected and monitored to detect inappropriate utilization trends. Examples include, but are not limited to, the following:

- Acute admits per 1,000 enrollees
- Inpatient days per 1,000 enrollees
- Long term acute care admits per 1,000 enrollees
- Rehabilitation admits per 1,000 enrollees
- Skilled Nursing Facility (SNF) average length of stay

- Readmission rates within 30 days
- ED visits per 1,000 enrollees
- Observation rate
- Post-Discharge care coordination referral calls
- 3M potentially preventable events (PPEs) metrics

We produce operational dashboard reports that aggregate data in a usable format to help identify enrollees who are high risk for high-cost utilizations or over-utilization of services. The UM Committee receives these metric trends reports monthly. These reports include those listed in Table 2.10.10.2.5-A.

Table 2.10.10.2.5-A: Operational Dashboard Reports	
Report	Description
Inpatient Census Report	Daily detailed account of acute and sub-acute inpatient facility admission cases
Inpatient Clinical Dashboard	Weekly reporting of key operational metrics, such as time from receipt of authorization to nurse receipt, time for clinical decisions, discharge plan documentation, enrollees contacted for post-discharge follow up, clinical program reach and engagement rate
Early Indicator Report (EIR)	Monthly reporting of key utilization metrics such as: admits/1,000 by utilization type (Acute, Skilled Nursing Facility (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, plan type, and age of user
Provider Utilization Profiling	Quarterly provider-level report of claims and encounter data to analyze under- and over-utilization and to provide peer-to-peer analysis
Predictive Model Reporting	Predictive Model Reporting - Predictive model for Severity Score, updated monthly, and Readmission Model, updated daily from admission to discharge, integrated into our clinical platform, CGX, to trigger referrals for clinical programs; ED Predictive Model scores available by report monthly and are integrated into CGX
Readmissions by Provider	Monthly tracking of 14- and 30-day readmission rate for acute admissions and physician visit within 14 days of discharge date.

We proactively monitor utilization trends to assess population health of our enrollees and identify gaps in care and areas for quality improvement. For example, **we provide daily ED visit reports to our providers** so they can conduct

follow-up with their enrollees who accessed the ED. We also analyze utilization data and produce a series of internal reports that monitor utilization at the population and enrollee levels.

Monitoring Pharmacy Utilization
We actively monitor, track, and report on pharmacy utilization and indicators to identify potential areas of over-utilization. We deliver reports to our network providers indicating potential areas of concern including reports on:
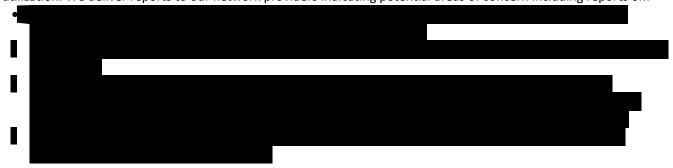
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Figure 2.10.10.2.5-A below includes a screenshot of our pharmacy analytic systems where we are able to monitor and report on pharmacy utilization.

Mitigating Over-Utilization
Humana monitors utilization trends to ensure enrollees are accessing efficient, but more importantly, appropriate, effective care. We collect, analyze, trend, and monitor data on a systematic basis to facilitate quality improvement and to address any barriers we identify. Trends may indicate improvement or reveal where we need to improve. Our comprehensive UM program has policies in place to both respond immediately to specific 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 during the entire hospitalization to close gaps in care and connect the enrollee back to their PCP. 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 conducts reviews of clinical data to inform its potential fraud, waste, and abuse (FWA) cases. The SIU uses our CGX platform to search and view medical prior authorization data, searching by authorization number and enrollee identification. Once it locates an authorization, the system provides authorization dates, approval status, relevant nurse documentation of the clinical timeline, and nurse phone call logs.

- In the mid-term: We proactively monitor utilization trends to assess 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 requiring complex medical management, BH interventions, SDOH barriers, and discharge coordination. The team discusses enrollee utilization patterns and current clinical needs. These include physical capabilities, family structure and support system, and emotional state. They also discuss potential problems 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. 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 a part of the first steps in our care management continuum to identify specific enrollee needs and to identify gaps in care. With this data, our CM can direct enrollees to the most appropriate care setting.

  > *Currently in Louisiana, we review admission data with providers, and through UM rounds to monitor for outliers in admissions, average length of stay, and readmissions*

- 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 over-utilization, we solicit input from healthcare professionals, providers, and other participants. 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 have 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 will bring this strength to the Louisiana Medicaid Program. If, based on our analysis of the Louisiana population, we identify an initiative from one of our other existing lines of business (Medicare, Commercial, or Duals) that we believe will drive measurable improvement in the health of Louisiana Medicaid enrollees, we have the capabilities and resources to quickly and efficiently implement that initiative.

2.10.10.3 The Proposer should describe its historical experience with utilization management of comparable populations. Such description should include:

2.10.10.3.1 Challenges identified with high utilization and increasing medical trends;

Through our experience conducting UM in our Florida Medicaid program, in our Kentucky Medicaid program, as well as in our Louisiana Dual Eligible Special Needs Plan (D-SNP), we have identified various challenges associated with high utilization and increasing medical trends.

Inappropriate use of ED: Various factors have contributed to our Florida Medicaid enrollees inappropriately accessing the ED. We found the lack of after-hours access to primary care, lack of awareness of other level of care options, and social determinants of health (food insecurity and homelessness) are major drivers of overutilization of ED services.

High rate of inpatient admissions due to sickle cell disease:

Access to primary and specialty care in rural and underserved areas: Increasing access to rural and underserved areas presents a challenge in our Florida program. When our enrollees cannot reliably access necessary primary care, they

turn to more costly, less effective care options. We also see the impact of lack of access in overall medical trends. Where there is underutilization of primary care services, there is an increase in high cost, low-value care in EDs, sometimes culminating in an inpatient stay due to the exacerbation of an existing conditions.

2.10.10.3.2 Initiatives undertaken to manage high utilization

Pharmacy Initiatives: We utilize Medication Therapy Management (MTM) in our high-need dually eligible, D-SNP population to help reduce the number of prescriptions enrollees are taking and identify possible drug interactions that could lead to serious health complications. Our MTM approach includes:

Comprehensive Medication Review (CMR)
- Comprehensive, real-time, interactive medication review and consultation between qualified provider and member
- Assess medication use for presence of medication-related problems (MRPs)
- Includes individualized written summary

Targeted Medication review (TMR)
- Focused on specific actual or potential medication related problems
- Assessments can be person-to-person or system generated
- Follow-up to resolve MRPs or optimize medication use

Real-Time ED Data Initiative: As mentioned earlier, we monitor live ED data in our Florida Medicaid program via our connectivity to the HIE-ENS. We receive real-time ED data from hospitals across the state. Upon notification we can engage CMs to contact the enrollee based upon risk stratification, educate the enrollee on accessing the most appropriate level of care, as well as produce daily ED reports to our network PCPs, notifying them that one of their patients visited the ED.

Sickle Cell Program:

Provider Engagement and Education: Humana Provider Relations representatives and provider-facing QIAs work with our providers to educate on high utilization trends for their enrollees and to develop solutions. Our provider engagement model allows us to work directly with our provider to track, monitor, and analyze utilization trends. We work with our providers to identify areas for improvement and to develop strategies to reduce potentially preventable ED visits, admissions and remissions. We **share monthly utilization metric reports** and **conduct quarterly meetings** with our providers to review data specific to their group, including:

Food Insecurity Pilot: Leveraging our membership, strong physician network, and relationships in South Florida, we developed and implemented a randomized control trial to test a food insecurity intervention. Working across three primary care clinics, we screened over 4,000 enrollees for food insecurity. Clinic associates were trained to provide the screening and utilize their EMR for the assessment tool. Approximately 1,400 patients screened positive and agreed to enroll in the study. About two thirds of the enrollees were placed in an intervention group, receiving case management-type services like education and accessing healthy foods via community resources and programs (including a partnership with Feeding America/Feeding South Florida). About one third of the enrollees were placed in the control group, also receiving information, but not with the oversight or case management support. Outcomes are being analyzed and prepared for publication in a peer-reviewed journal.

Expanded Urgent Care Network: Humana recently expanded our urgent care network in Florida to extend access to appropriate care settings. Instead of visiting the ED for a non-emergent condition, we educate enrollees to use urgent

care centers as a more appropriate care setting. We include information on urgent care centers via multiple channels including the: Member Handbook, Provider Directory, provider and enrollee portals, and through the NAL. As a result, **we have seen an increase in urgent care utilization, and a decrease in ED utilization.**

Multidisciplinary Team (MDT) Meetings: Our integrated care delivery model includes MDT meetings through which our internal clinical team, the Comprehensive Care Support (CCS) team, reviews high utilizer cases. The MDTs connect enrollees and providers to develop an individualized care plan to address the drivers for high utilization, including SDOH resource needs.

2.10.10.3.3 Initiatives to address use of low value care

Clinical Practice Guideline Adherence: We have found that provider adherence to clinical practice guidelines (CPGs) correlates to delivering high-value care. If a provider is identified as an outlier, a Louisiana Medical Director will evaluate the provider for consideration of corrective action. This may include provider education through QIAs, a review of enrollee medical records, or if the negative trend continues post-education, presentation to the Peer Review committee.

Addressing Under-Utilization: Humana UM processes also identify areas where enrollees may be underutilizing key preventive or supporting services, leading to an increase in low-value care. Through review of utilization data, we are able to identify enrollees who may not have been identified for case management upon enrollment or through their PCP. We reach out to those enrollees to see if they will engage in case management. We monitor under-utilization for those enrollees in case management through CM, enrollee, and PCP interaction. The CM is often in the best position to understand the needs of the enrollee and identify areas where they could benefit from more services. Our UM nurses, as well as CMs, work with the enrollees to determine if additional services are medically necessary and would be beneficial for the enrollee and family.

Additionally, we use the UM process to identify enrollees who may not be receiving the appropriate amount of services for their identified condition or situation. Under-utilization can accompany racial and ethnic health disparities stemming from lack of access to culturally competent care. Humana QIAs work with our providers to review utilization patterns and identify areas for improvement, such as closing gaps in preventive care, in order to promote appropriate utilization and improved health outcomes.

2.10.10.3.4 Initiatives to address long term stays of enrollees in the ER based on limited availability of mental health and/or substance use services

Addressing ED Stays for Mental Health and/or Substance Abuse Services
We recently implemented new strategies to decrease the number of enrollees seeking care for mental health and substance use disorder (MH/SUD) service in the ED, and strategies to quickly identify those enrollees who do present at the ED and transfer them to the most appropriate care setting.
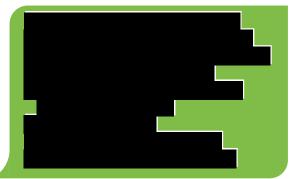
When an enrollee presents at the ED with BH needs, we work with the hospital/ED to find availability in an appropriate setting as soon as possible. If the ED is able to find an available MH/SUD bed, the ED will notify our CIT to begin the authorization process. In some cases, our CIT assists the ED in finding a facility the bed availability. This process initiates a request via our clinical platform, CGX, for the BH UM team to try to secure a bed at an in-network facility. **If we are unable to find an in-network facility, we direct them to the closest out-of-network facility.**

We are working to improve our real-time notification of BH-related ED visits through increased participation in HIEs through which we can receive real-time data transfers. In our Florida Medicaid program, we receive daily ED reports via the state's HIE-ENS **containing primary and secondary BH diagnoses**, allowing us to immediately reach out to the facility and determine if the enrollee needs to be transferred.

Keeping Enrollees with BH Needs out of the ED
We have found the most effective way reduce ED stays for MH/SUD services is to divert those enrollees away from the ED with more effective outpatient services or community resources. We have developed value-based purchasing partnerships with the community mental health centers (CMHC) in Florida in an effort to prevent our enrollees from accessing the ED. We have contracted with the CMHCs for crisis stabilization units and increased bed availability, mobile crisis services and home-based therapy visits.

We have also found that eliminating provider administrative burden regarding authorizations assists in connecting our enrollees with the appropriate care as fast as possible. BH providers will be a part of our Gold Card program, whereby high performing providers can bypass authorizations for most services.

2.10.10.3.5 Initiatives undertaken to support providers with high prior authorization denial rates

When we identify a provider that has high prior authorization denial rates, either through data analysis or through provider communication, our first course of action is to determine the reason for the denials. In many cases we find that providers are not aware of clinical practice guidelines for ordering specific diagnostic procedures and tests (e.g., MRIs for early diagnostic screening and invasive procedures such as cardiac catheterization). Humana's approach is to partner with our providers to educate on the most recent evidence-based clinical studies and protocols when we identify patterns of denials that do not adhere to nationally accepted clinical practice standards. We take a hands-on approach in consulting with the provider through peer-to-peer consultation. We work with providers to determine if they are utilizing clinical protocols and coding the authorization correctly, if there is vital information consistently missing from the authorization, or if there are other underlying causes. Once we determine the reason for the denials, we work with the provider through education with our local clinical teams, Medical Directors, and Provider Representatives to aid in providing the highest quality of care to our enrollees. We particularly focus on education about our pharmaceutical formulary, clinical practice guidelines, and prior authorization lists to ensure our providers understand how to access both lists.